



Republic of Namibia

Ministry of Health and Social Services

National TB and HIV Targets



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Foreword

In line with global commitments to scale up HIV and TB interventions and in recognition of the need for strengthened accountability, Namibia engaged in a consultative process to develop a set of HIV and TB indicators and targets. These targets map the way toward achieving universal access of prevention, treatment, care and support for HIV and TB.

Building on previous efforts to identify targets for the Third National Development Plan (NDP III) and the Medium Term Plan III (MTP III) costing exercise, the Ministry of Health and Social Service (MoHSS) organised a consensus building workshop to collaboratively define Namibia's HIV and TB targets for the periods 2009/10, 2011/12 and 2014/15. The workshop was held at Heja Lodge, near Windhoek on 11-14th February 2008.

This report describes the targets developed as well as the assumptions, obstacles and solutions for reaching those targets.

We are very pleased to have reached this important milestone in our national planning process. This achievement shows our genuine commitment toward scaling up HIV and TB interventions. The joint effort made by over 100 stakeholders who worked collaboratively to develop these targets is remarkable yet essential for us to continue improving our national response. By mapping out how to provide essential HIV and TB services to all Namibians we have met our commitments made at the African Union Conference in Brazzaville in March 2006 to set national targets. This commitment was reaffirmed at the United Nations 2006 High Level Meeting on AIDS in June of that same year.

The targets developed will feed into important processes such as: the development of MTP IV (HIV/AIDS) and MTP II (TB); the Round 8 Global Fund application and other resource mobilisation efforts. Furthermore, it will benefit sectoral planning processes and annual work planning of all stakeholders (government, civil society partners and development partners).

The collaborative work of developing the targets is also intended to promote greater partner alignment to the national HIV and TB priorities, strengthen accountability and facilitate efforts by the government and development partners to mobilise international support and resources.



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LIST OF ABBREVIATIONS & ACRONYMS

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Ante-natal Clinic
ART	Anti-retroviral Therapy
ARV	Anti-retroviral
BCC	Behaviour Change Communication
CACOC	Constituency AIDS Coordinating Committee
CDC	Centres for Disease Control and Prevention
COMBI	Communication for Behaviour Impact
C&T	Counselling and Testing
DHS	Demographic and Health Survey
DSP	Directorate: Special Programmes
EU	European Union
ePMS	electronic Patient Management System
EPP	Estimation and Projections Package
ETR	Electronic TB Register
FBO	Faith-based Organisation
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	Gellschaft für Technishe Zusammenarbeit
HAART	Highly active anti-retroviral therapy
HBC	Home-Based Care
HIS	Health Information System
HIV	Human Immuno-deficiency Virus
IEC	Information, education, communication
IMAI	Integrated Management Adult Illnesses (IMAI),
KAP	Knowledge, attitudes, practices
M&E	Monitoring and evaluation
MCH	Maternal and Child Health
MoHSS	Ministry of Health and Social Services
MSM	Men having Sex with Men
MTP III	Third Medium Term Plan on HIV/AIDS
MTP IV	Fourth Medium Term Plan on HIV/AIDS
MTP I	First Medium Term Plan on TB
MTP II	Second Medium Term Plan on TB
MGECW	Ministry of Gender Equality and Child Welfare
NABCOA	Namibia Business Coalition on AIDS
NAC	National Aids Committee
NAEC	National Aids Executive Committee
NAMACOC	Namibia Multisectoral HIV/AIDS Coordinating Committee
NACOP	National Aids Coordination Programme
NBTS	Namibian Blood Transfusion Service
NANASO	Namibia Network of AIDS Service Organisations
NASOMA	Namibia Social Marketing Association
NGO	Non Governmental Organisation
NIP	Namibia Institute of Pathology
NPC	National Planning Commission
OVC	Orphans and Vulnerable Children
OMAs	Government Offices, Ministries or Agencies
OPM	Office of the Prime Minister
PEP	Post Exposure Prophylaxis
PCR	Polymerase Chain Reaction

PEPFAR	The US President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother To Child Transmission
PWP	Prevention with positives
RACOC	Regional AIDS Coordinating Committee
RH	Reproductive Health
RT	Rapid Testing
RM&E	Response Monitoring and Evaluation Subdivision
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
UDS	Urethral Discharge Syndrome
USAID	United States Agency for International Development
USG	Unites States Government
WHO	World Health Organisation

EXECUTIVE SUMMARY

In 2007 there were approximately 40 new HIV infections every day. 44% of these new infections were among 15-24 year olds. (MoHSS, 2008)

Over the past 22 years since the first cases of HIV infection were recorded, Namibia has made considerable strides in its response to HIV and TB. The country has achieved some of the targets stipulated in the current strategic frameworks MTP III (HIV/AIDS) and MTP I (TB). However, the achievements reached to date should not lead to a complacent attitude towards these epidemics. The 2006 HIV Sentinel Survey, data from our TB registers and recent projections show that even more drastic measures are needed to prevent new HIV and TB infections while sustaining a high level of care for those infected and affected. Thus, continuous concerted efforts need to be made in order to achieve the national goals and reduce the incidence of HIV and TB in Namibia.

In view of the changing landscape of the epidemics and newly available data, a four day workshop entitled 'National Target Setting Workshop for TB and HIV' was organised by the Ministry of Health and Social Services, Directorate of Special Programmes (MoHSS DSP) in close cooperation with UNAIDS, the European Union, the US Government, and other stakeholders. The workshop was held at Heja Lodge, near Windhoek from 11-14 February 2008. The main objective of the workshop was to collaboratively formulate and build consensus around a set of final programme and national level indicators, and set targets against those indicators from baseline (anytime between 2000 and 2003) through 2014/15, which will guide the development of the subsequent national strategic frameworks for HIV and TB.

This report describes the targets developed as well as the assumptions, obstacles and solutions for reaching those targets.

In 2005 members of the United Nations recognized that the only way to reach the Millennium Development Goal of reducing new infections in HIV, TB and Malaria was to roll out services to all members of society. By providing universal access to services to all citizens, national goals could be achieved. In March 2006, members of the African Union signed the Brazzaville Declaration, committing their countries to setting national targets toward universal access. A few months later, at the UN 2006 High Level Meeting on AIDS, this commitment was reiterated. To achieve universal access, a nationally-derived, feasible set of targets needs to be set. These targets should be set within the existing country frameworks and should map out the milestones to reach universal access.

Targets have been set previously in Namibia for the national strategic frameworks for HIV and TB. New information available from our monitoring systems provides an opportunity to revise the existing set of targets. These were often broad and did not provide enough detail to effectively monitor the epidemics. Hence, it was necessary to update the targets and identify a smaller set of national targets which are more specific and measurable. It is important to note that the targets set in these previous exercises were used as the starting points for developing the updated targets during the workshop.

A set of 14 national indicators and 39 programme indicators were formulated and agreed upon during the target setting exercise. For each indicator the numerator, denominator, baseline (if available), data source and targets for the afore-mentioned periods were defined. In addition, the assumptions upon which the targets are based, the obstacles and recommendations are described for both programme and national level indicators.

Instrumental to this process was:

- The broad participation of over 100 HIV and TB stakeholders (MoHSS, other ministries (Office of the Prime Minister, National Planning Commission, Ministry of Gender Equity and Child Welfare etc.), faith-based organisations, civil society, private sector and development partners, umbrella organisations) and the commitment shown by them to build consensus throughout the entire process.

- The clear methodology used, combined with the relevant documentation¹ and useful information² supplied, and support provided by the programme leaders and monitoring and evaluation (M&E) facilitators.

As background for the participants developing the targets, the HIV estimates derived from the Estimation Projection Package and Spectrum model³ were explained, the assumptions were described and the estimates and projections were reviewed. Some crucial values taken from the Spectrum model are presented in the table below. One of these values is the National Adult HIV Prevalence Rate of 15.3% for 2006/07. This estimated value gives a more representative picture of the current prevalence in the general population (men and women aged 15-49) as opposed to the 19.9% HIV prevalence amongst pregnant women attending antenatal clinics (Sentinel Survey, 2006). The model results are available in a separate document: Estimates and Projections of the Impact of HIV/AIDS in Namibia (MoHSS, forthcoming).

After a review of the methodology for developing targets, participants worked in small groups identifying indicators and setting targets for specific programme areas. For each programme area, the assumptions that underpin the target setting process, the obstacles and solutions for the obstacles were put forward. After the programme targets were developed, participants chose a sub set of targets against which national progress in prevention, treatment, care, support and governance could be effectively measured.

The indicator matrices for national and programme indicator level are presented respectively in annexes one and two.

The most frequent assumptions made when setting the targets were: continued financial funding from government and development partners; availability of infrastructure and other resources; improved data collection and harmonised M&E reporting systems; and increased availability of human resources both in terms of quality and quantity.

Some of the reported obstacles that may hamper the achievement of targets in prevention are: lack of coordination and lack of male involvement. In the area of care and treatment it is predominantly lack of skilled human resources and lack of access to services particularly in rural areas. Core obstacles in the area of enabling environment are mainly lack of human resources (both quality and quantity) and budgetary constraints. Finally in the field of governance, it was felt that leadership commitment needed to be strengthened and a sense of urgency brought to the HIV response.

The following recommendations were made to ensure consistent and accurate measurement of the targets:

- A nationally representative survey including HIV testing is critical for improving Namibia's measure of HIV prevalence.
- The main challenge in Namibia is the prevention of new and secondary infections, which requires consistent measures of behaviour change. Thus, more frequent nationally representative surveys are needed to measure progress.
- It is important to avoid small scale Knowledge Attitude and Practices (KAP) surveys, and rather utilise funds for nationally representative, high quality surveys. This requires a coordinated execution of the M&E plan.
- Surveys for key vulnerable groups (sex workers, men who have sex with men, prisoners) are particularly needed.
- It is important to ensure that more consistency for future programme data reporting is guaranteed.

¹This included, amongst others, copies of MTP III for HIV, MTP II for TB, the Namibian 2008 United Nations General Assembly Special Session on HIV/AIDS (UNGASS) Report, the Plan for National Multisectoral Monitoring and Evaluation, Revised HIV/AIDS Costing Report for MTP III, 2006 HIV Sentinel Survey Report and Preliminary results of the Demographic and Health Survey (2006)

²This included short presentations on the Universal Access Initiative, UNAIDS presentation on lessons learnt from similar target-setting exercises in the region and the modeled estimates and projections.

³This is a modelling software package that provides the denominators necessary for setting targets such as number of people in need of ARVs, number of people living with HIV, number of HIV positive pregnant women etc.

- Surveys for key vulnerable groups (sex workers, men who have sex with men, prisoners) are particularly needed.
- It is important to ensure that more consistency for future programme data reporting is guaranteed.
- Quality assurance checks should be put in place to ensure a high level of confidence in the accuracy of the data being reported and used for programme planning.

The targets were presented and approved by the National Aids Executive Commission (NAEC) on 27 February 2008. In addition the report was presented for review to the National Multi-sectoral AIDS Coordinating Committee (NAMACOC) in March 2008.

The targets developed will be fed into important processes such as: the development of MTP IV (HIV/AIDS) and MTP II (TB); the Round 8 Global Fund application and other resource mobilisation efforts, sectoral planning processes and annual work planning of all stakeholders (government, civil society partners and development partners).

1. INTRODUCTION

In this report a detailed description is given of the process and outcomes of the national TB and HIV target setting process in Namibia. This document by no means intends to provide a comprehensive picture of Namibia's response to HIV/AIDS and TB. More information on Namibia's HIV and TB strategies and progress against those strategies can be found in other sources.

This chapter provides some background to the target setting process, including the overall rationale, objectives, participants and methodology of the target setting workshop. The next chapter provides a brief overview on the estimates and projections models, followed by the programme and national level indicators and targets. The overall conclusions and next steps from the target setting process are presented in the final chapter.

1.1. BACKGROUND

At the Group of 8 meeting held in July 2005, the concept of ensuring "Universal Access" to HIV prevention, treatment, care and support services by 2010 was introduced. The Africa Union endorsed the concept during the Brazzaville Declaration in 2006. The overall purpose of Universal Access is to provide services to all people who need these services, striving for 100% coverage, although this is very ambitious even in more affluent countries. All countries present, including Namibia, committed to scale up and sustain HIV and AIDS services by 2010 and beyond for universal access. Important to the target setting process is that the targets set should be realistic and ambitious and should take into consideration the prevailing national context.

The process of targets setting for universal access should not be done in isolation, but should be in line with the national strategic frameworks. The MTP III provides the national framework by which all stakeholders should cooperate to reach the objectives of the national response to HIV. Similarly, the National Strategic Plan on TB describes the framework, goals and strategic results around TB. Within both strategic plans, targets were created against which to measure progress toward the overall goals.

Over the past few years, a great amount of effort and resources have been mobilised to facilitate the roll-out of HIV and TB services nation-wide. Despite these achievements, the country still has not reached many of the targets set out in the strategic plans. Based on the 2006 HIV sentinel surveillance results, it is evident that despite the great efforts made to date, the current efforts are not making the expected impact on preventing new infections.

In addition the monitoring and evaluation systems for both diseases have improved in recent years. An electronic TB system has recently been rolled out as well as an electronic patient monitoring system for persons on ARVs. HIV sentinel surveillance is taking place every two years among pregnant women and national behavioural surveillance occurs every five years among the general population. Additional tools such as the web-based literature database and funding database provide additional information to help understand and measure the response to the epidemics.

To achieve the national goal of slowing TB and HIV incidence and reducing the impact of AIDS, a feasible set of targets needs to be set. Previously preliminary targets were set for the national strategic frameworks for HIV and TB during a costing exercise organized by the Directorate of Special Programmes (DSP) in February 2007. The purpose of this exercise was to collaboratively estimate the costs required for the HIV response and set targets for three scenarios (high, medium and low).

The recent availability of new data from the 2006 Demographic and Health Survey (DHS), HIV Sentinel Surveillance (2006), the output generated from the Estimations and Projections Package and the Spectrum¹ model, as well as the changing landscape of the response, require that all stakeholders reconsider their initial targets and reflect upon the current status of the epidemics to ensure that Namibians have access to the quality and type of HIV and TB services they require. In addition the

¹Both models will be discussed in chapter 2 in further detail.

previously defined targets were often too broad and not useful to effectively manage the epidemics. Thus, it was necessary to update the targets and identify a smaller set of national targets which are more specific. This would reduce the overall number of targets to a manageable and measurable number.

The MoHSS facilitated the target setting process with all the above in mind and with the sole purpose of reaching consensus on updated national and programme level targets for HIV and TB. This consensus-building process will help harmonise the HIV and TB response efforts that are so needed in Namibia. In the long term, the efforts made will focus stakeholders on specific targets, push stakeholders to identify obstacles in reaching targets, strengthen accountability and assist in planning and resource mobilisation. In addition, the process should promote a team approach by government, civil society, the private sector, faith-based organisations and development partners.

The results of the workshop will feed into the processes listed below:

- The development of MTP IV (HIV/AIDS)
- The development of MTP II (TB)
- The Round 8 Global Fund application
- Resource mobilisation efforts
- Sectoral planning processes
- Annual work planning and monitoring of all stakeholders (government, civil society partners and development partners)

1.2. MAIN OBJECTIVES

The overall objective of the process was to build consensus amongst key stakeholders in the field of HIV and TB on national targets which demonstrate how Namibia will scale up its response to HIV and TB.

The following specific objectives were defined:

1. To brief stakeholders on models used to estimate and project underlying information on HIV, and agree on final results.
2. To identify programme level TB and HIV indicators against which to measure targets.
3. To agree on baseline data for those indicators.
4. To identify programme targets, as well as obstacles to and assumptions for reaching those targets.
5. To identify a sub-set of nationally-owned targets.

1.3. KEY STAKEHOLDERS

An effective HIV and TB response requires a multi-sectoral approach which is characterised by full ownership, commitment and buy-in from all sectors involved in the process. This includes other ministries (OPM, NPC, MGEWCW etc.) working on HIV, private sector firms providing HIV services, faith-based organisations, development partners and civil society. Over 100 stakeholders participated in the process of developing the national HIV and TB targets. Please refer to annex 3 for the complete list of participants.

1.4. SUMMARY OF TARGET SETTING WORKSHOP

A committee consisting of representatives from various development partners and MoHSS DSP subdivision Response Monitoring and Evaluation (RM&E) was tasked to oversee the overall organisation, moderation and follow-up of the workshop activities. Please refer to annex 4 for the workshop programme.

Day 1

Objective: To review the models from which we derive our HIV estimates and projections including the assumptions used, and the output estimates and projections

During the first day, the Deputy Director of Health Sector Response DSP/MoHSS presented the meeting objectives. He mentioned that this target setting exercise plays a crucial role in Namibia's national planning process in its response to HIV and TB. Furthermore, he mentioned that it is an ongoing exercise as data will improve as we go along. He finalized by stressing the importance of all stakeholders being informed, reaching consensus and aligning around one M&E framework.

The next presentation was by the Country Coordinator for UNAIDS who shared the experience and successes with setting national targets in Malawi, Mozambique, Swaziland and Lesotho. From this presentation it became clear that these countries successfully formulated a manageable (often 7-9 indicators) yet ambitious set of targets. UNAIDS also presented the relevance of the workshop in the wider global context, and how this work will contribute toward providing universal access to prevention, treatment, care and support for HIV and other diseases.

The Chief of Programmes, DSP subdivision RM&E, explained the relevance of the workshop in relation to other processes such as MTP IV and Global Fund Round 8. She also stated that the targets set during the costing exercise (February 2007) will be fed into this workshop. Finally, she presented the workshop programme, explained the workshop methodology and expected outcomes (see section 1.5 for further details), and described the next steps after the workshop.

The greater part of the day was focused around the HIV estimates and projections developed from models. RM&E presented data which have been extrapolated from the models and are very useful for target setting as they provide estimates of the denominators for key indicators. Consensus was reached on the proposed national HIV adult prevalence rate of 15.3 percent for Namibia. Finally, the day ended with a summary of the main issues and concerns raised during the presentation on the HIV estimation models. Please refer to chapter 2 for further details.

Day 2

Objective: To review programme indicators and decide on targets

After the methodology for reviewing and setting feasible targets was presented, the attendees spent most of the day in groups reviewing and developing programme level targets. The groups were provided with the current values of indicators, and baselines where available. Based on the information supplied, the groups reviewed and set targets for the end of financial years 2008/09; 2010/11 and 2014/15. The latter period was based on extrapolated projections from previous years. The programme areas on Day 2 were primarily related to the health sector and focused on the following programme areas: Prevention of Mother To Child Transmission (PMTCT), TB, Counselling & Testing (C&T), Sexually Transmitted Infections (STIs)/Condoms/ Reproductive Health, Anti-retroviral Therapy (ART), Blood safety/Post Exposure Prophylaxis (PEP)/Medical injections.

Day 3

Objective: To review programme indicators and decide on targets

The objective and approach were similar to those of day two with stakeholders from the multi-sectoral programme areas: Workplace Programmes, Governance, regional support and mainstreaming; Home Based Care (HBC) and Palliative Care; Behavioural Change Communication (BCC) and Vulnerable Groups. The HBC deliberations resumed after the workshop. Due to lack of good data and time constraints it was decided to exclude the programmes food security from this target setting exercise. Please refer to chapter 3 for an overview of all programme level targets.

Day 4

Objective: To agree on a set of national targets (subset of programme targets)

After the methodology was explained, participants were asked to review the programme area submissions and select a small set of national targets against (all programmes nominated one

indicator for national target setting) which universal access to prevention, treatment, care and support will be effectively measured for HIV and TB. Upon completion of this exercise, the Director of DSP facilitated the final adoption of the workshop output, namely a set of 14 national indicators. In chapter 3 the results of this exercise are presented.

1.5. METHODOLOGY

Leaders in each programme area were identified and briefed before the workshop on the target setting process. These individuals facilitated the process of identifying programme level indicators and setting targets against those indicators. Each working group was also assigned an M&E facilitator to ensure the indicators developed were in line with current data collection efforts and the national M&E plan. Below is an outline of the approach for the group work:

1. Identify critical indicators against which to measure targets
2. Agree on baseline data for those indicators
3. Set medium- and long-term targets for 2009/10, 2011/12 and 2014/15⁵ (using data from the costing exercise as reference)
4. Identify obstacles to reaching those targets
5. Record assumptions⁶ used in developing those targets
6. Nominate a key indicator for national level⁷

A resource pack was supplied to each group with relevant documentation for their specific programme area. For HIV programmes the following information was supplied: Plan for the National Multi-sectoral Monitoring and Evaluation of HIV/AIDS, 2008 Namibia UNGASS reports, Revised Costing of Namibia's 3rd HIV/AIDS MTPIII, the Preliminary results of the 2006 Demographic and Health Survey and the HIV Sentinel Surveillance Report. For TB the packet consisted of the National Tuberculosis and Leprosy Control Programme Annual Report, the Preliminary Results of the 2006 Demographic and Health Survey.

Finally, all implementers, including civil society organisations, the private sector and PLWHAs had to ensure that the reality on the ground formed the basis for the target-setting process.

⁵ Model estimates are not available for the period 2014/15, so all groups had to make extrapolated projections based on their own assumptions.

⁶ This is important for future reference as it provides the basis upon which assumptions were defined. Thus during the workshop groups were encouraged when scaling up efforts over time to keep a holistic view of the programme development and take the sustainability of the programme into account.

⁷ No national indicator was nominated for some areas because the proposed programme indicators were not strong enough to consider for national targets.

2. HIV ESTIMATES FROM MODELS

This chapter provides an overview of the models used to derive HIV estimates and projections and the discussions held around the models during the workshop. No modeling data were available for the TB response. For more detailed information please refer to the forthcoming document 'Estimates and Projections of the Impact of HIV/AIDS in Namibia (MoHSS, forthcoming), where the assumptions and results of the models are published.

An important prerequisite in a target-setting process is to first agree upon the number of people in need of services. UNAIDS, WHO and partners have developed a model to estimate and project national HIV prevalence based on ANC HIV prevalence and other information. The model is called the Estimation and Projections Package (EPP) and complements a further modeling software called Spectrum. Using national demographic data, programme coverage data, and assumptions of future programme coverage, patient retention, and survival, Spectrum can estimate the number of people newly infected, number of people living with HIV, the number of women who will need PMTCT services, and the number of people in need of ART. The model can project these estimates for up to five years into the future, beyond that period the estimates become unreliable. It is important to note that the models assume that prevention efforts will stay constant over the next five years.

The models estimate adult national HIV prevalence to be 15.3 percent in 2006/07. It is important to explain that this value is different than the 2006 HIV Sentinel Surveillance results of 19.9 because the sentinel surveillance provides prevalence among pregnant women only. The adult HIV prevalence gives a more representative and accurate picture of the epidemic's level among both men and women. HIV prevalence is higher among women attending ante-natal clinics (ANC) because ANC attendees are not using condoms consistently, the pregnant women do not accurately represent the male population, and the Sentinel Sites tend to be biased toward urban settings.

Some of the results from the models are presented in Table 1. HIV prevalence among men and women aged 15-49 is projected to stay fairly constant over the next five years (again, assuming no change in prevention efforts). However, due to the growth in the population living with HIV over age 50, the number of people living with HIV will continue to grow. In addition the population in the 15-49 year age group will continue to grow, so even if the percentage of adults living with HIV stays constant, the total number will increase. (Note measuring adult prevalence as HIV prevalence among men and women ages 15-49 is a global standard.)

Similarly, because the number of people on treatment will continue to grow in the next five years, the number of people dying of AIDS related causes will also continue to grow despite the roll-out of ARVs. This reflects the aging of the population on ARVs who will also likely die of other causes.

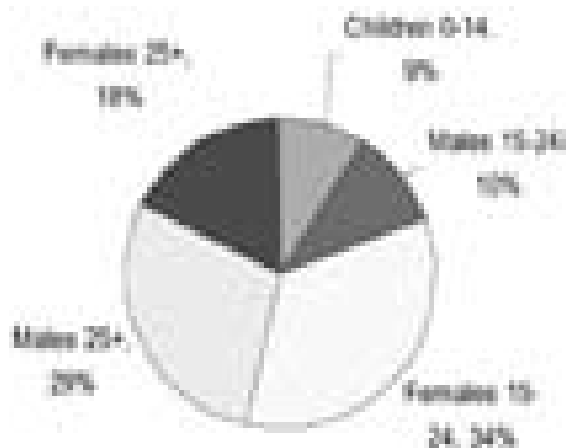
Table1: Spectrum values for March 2007 – March 2012

Estimates and Projections from Spectrum	March 2007 ⁸	March 2012
Adult HIV prevalence	15.3%	15.9%
Estimated number of people living with HIV	196,000	239,000
Estimated number of new infections	14,800	15,700
Estimated number of women in need of PMTCT	9,400	10,000
Estimated number of children needing ART	5,000	7,500
Estimated number of adults needing ART	54,800	99,200
Estimated number of children and adults receiving ART	40,400	87,700
Estimates number of deaths due to AIDS	5,400	6,800

Figure 1 depicts the distribution of HIV in 2007. (The GRN fiscal year from April – March were used in the model.) It shows that there were 40 new HIV infections every day. Furthermore, it is reported that 44 percent of these new infections are among 15-24 year olds. This suggests that prevention efforts must be targeted at this young age group who are just becoming sexually active and forming their sexual behaviour and habits.

⁸ The Namibian government's financial year ranges from 1st April – 31st March

Figure 1: Distribution of HIV infections in 2007



Based on the Spectrum model the following conclusions are made:

- New infections will stay at approximately 16,000 per year for the next five years unless effective prevention programmes are initiated immediately.
- HIV prevalence among 15-49 year olds is stabilizing but not dropping, in fact a slight rise is still projected through 2012.
- Despite the stabilising trend in the prevalence among 15-49 year olds, there will continue to be an increase in the number of people living with HIV as the total size of the population in this age group increases and as large numbers of people living with HIV age out of the 15-49 year age range.
- Number of people in need of ARVs is projected to continue to rise rapidly, almost doubling between 2006 and 2012 (from 60,000 to 106,000)
- Estimated HIV-related mortality grew steadily from 1988 to 2005, with a small decline in 2006. The decline was probably due to treatment.
- HIV mortality is likely to begin rising again after 2009, due in part to default and death of patients on treatment. This highlights the importance of programmes to improve adherence and patient retention in the ART services.
- Spectrum output for number of orphans appears to be underestimated. Proportions of children orphaned from the DHS will be used to estimate the number of orphans. The preliminary 2006 DHS results suggest that 17% of children ages 0-17 have lost one or both parents (death due to any cause). This resulted in approximately 155,000 children in 2006/07 having lost one or both parents.

A number of assumptions are required for the models. While reviewing these assumptions a few issues were brought up by the participants during the workshop, which are noted below.

- Regarding PMTCT's roll-out, questions were raised about whether multiple drug therapy will be available to all clinics by the end of 2008. This assumption was seen to be optimistic.
- The model uses a default value of the survival times of adults on ARVs. The default suggests that 85% of adults starting treatment will survive one year. However, recent research from neighbouring countries has proposed that this value might be closer to 65%. This new information will be considered by the developers of the model and adjustments will be made accordingly. Alternatively, if high quality survival data are available from Namibia, these data can be used in the model.
- The values projected on the need for 2nd line treatment seemed to be different (higher) than what is seen in practice. Data should be monitored on this for the next year to adjust future models.
- The level of treatment for children seems high given that only 65% of women are currently reached with PMTCT services. Thus coverage of PMTCT should be monitored over time and the model should be adjusted accordingly.

- The model estimates the number of children in need of cotrimoxazole treatment. This is adjusted based on whether there is Polymerase Chain Reaction (PCR) testing available in the country. In Namibia PCR is available in some sites and this was noted as a model input. However, without describing the level of PCR testing coverage the model is likely to inaccurately estimate the proportion of children in need of cotrimoxazole. These data should be interpreted with care.
- Finally, the participants recognized that the models rely heavily on information from neighboring countries. Without a nationally based household survey collecting data on HIV prevalence, there will continue to be high levels of uncertainty in Namibia's estimates and projections.

3. TARGETS

This chapter presents the targets set for national and programme indicators. National targets reflect the higher level outcome and impact targets that should be reported on when measuring the national response toward universal access. The programme level targets are for programme use and should be used when producing programme specific reports on the response in that area. Not all programme areas have a national indicator as some areas did not identify an indicator that was strong enough to be measured as a national outcome or impact. Please refer to annexes one and two for a matrix of the national and programme level indicators, respectively.

For each programme area the following items are outlined: a short background⁸, an indicator matrix which includes a list of agreed national and programme indicators with corresponding targets the assumptions made when deriving the targets, the obstacles identified to reach the targets and proposed solutions to those obstacles.

Food assistance is felt to be one of the critical areas for the national response to HIV and TB, However there were no clear indicators neither were there any good data to measure food assistance. Thus no targets (national or programme) were set for food assistance.

3.1. ANTI RETROVIRAL TREATMENT (ART)

The public ART programme was launched in Namibia in mid 2003. The national target of reaching 30,000 people on ART by 2008, which was originally set by MTP III, was achieved in the fiscal year 2006/07. By mid 2007 all 34 district hospitals and some health facilities/clinics were providing ART services. Strong government leadership combined with increased donor support has been instrumental in the successful roll-out of ART. Furthermore, a rapid process of establishing more sites for ART provision was facilitated by consensus-building around national guidelines, the roll-out plan, training programme, information systems, the recruitment of physicians, pharmacist, nurses and community counsellors, and other technical support.

Indicator Matrix

Programme indicators	2000-03	2006/07	2009/10	2011/12	2014/15
Percentage of adults and children (0-14) with HIV still alive at 12 months after initiation of antiretroviral therapy	NA	A 69% C 82%	A 80% C 87%	A 85% C 92%	A 90% C 95%
National indicator	2000-03	2006/07	2009/10	2011/12	2014/15
Percent of adults and children (0-14) with advanced HIV infection receiving ART	A 0% C 0%	A 56% C 88%	A 70% C 90%	A 80% C 90%	A 85% C 90%

Assumptions

The targets set are based on the following assumptions:

- All stakeholders providing ART (private sector, medical aid, Ministry of Defense) will feed data into the electronic Patient Management System (ePMS).
- Integrated Management of Adult Illnesses (IMAI) will be rolled out as scheduled.
- Uninterrupted availability and accessibility of services (without financial barriers).
- ART outreach is maintained and expanded.
- Children get into care and treatment early, with availability of early infant diagnosis.
- Adults get into treatment earlier in the course of infection.
- Coverage of both indicators will level out over time as IMAI, PCR and ART roll-out will be strongest in earlier years.
- Patients will maintain or improve on their adherence (adherence surveillance and Information Education and Communication (IEC) will accelerate).
- Continued low levels of infection with drug resistant viral strains.

⁸ The background provided on each programme area are taken from the MTP III Mid-term Review report (July 2007), 2008 Namibia UNGASS Report, HIV Sentinel Survey Report (2006) and DHS (2006).

Obstacles and Solutions

The following obstacles and solutions were proposed. Please note that the list is not exhaustive:

Obstacles	Proposed Solutions
Limited human resources	Revise staff establishment structures and fill vacant positions
There is an overall shortage of health workers and lack of health workers trained in the latest ART guidelines	Develop policy for task shifting
	Scale up training on ART, IMAI and integration of services
Limited Infrastructure	Develop a costed plan for renovation and expansion of facilities
There is a lack of space for facilities, including centralised laboratory capacity for clinical monitoring and access to services.	Develop a plan for decentralisation of laboratory services for clinical monitoring
Stigma and discrimination	
Lack of food and adequate nutrition	Make nutritional supplements available to care and treatment patients
Lack of male testing and difficulty with getting men into care	Use COMBI as a vehicle to improve male utilisation of services
No appropriate measure for service accessibility	
Lack of transport for patients/access in rural areas care	

3.2. PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT)

In March 2002, the MoHSS introduced the Prevention of Mother to Child Transmission of HIV (PMTCT) programme as a pilot in Katutura and Oshakati State hospitals. By March 2007, 170 health facilities were providing PMTCT services (including all 34 district hospitals). Efforts to further scale up this programme are on-going. Medicines for PMTCT are available and financially supported, while the overall PMTCT-Plus programme is supported by various development partners.

Indicator Matrix

Programme indicators	2000-03	2006/07	2009/10	2011/12	2014/15
Percent of all pregnant women attending first ANC visit who received results of HIV test	0%	58%	70%	85%	90%
Percent of HIV exposed infants receiving DNA/PCR test within 8 weeks of birth	0%	15%	25%	45%	60%
National indicator	2000-03	2006/07	2009/10	2011/12	2014/15
Percent of pregnant HIV+ women receiving a complete course of ARV prophylaxis	0%	65%	75%	80%	85%

Assumptions

The targets set are based on the following assumptions:

- Rapid testing roll-out will accelerate.
- Roll-out of dried blood spot and PCR testing will take place
- The current data management system will improve, including an integrated data management system for maternal/child health, including PMCT/PCR, will be developed and rolled out.
- HIV testing will be offered at every antenatal clinic.
- There will be increased and continued funding.
- All HIV positive pregnant women will have access to ARV prophylaxis or Highly Active Anti-retroviral Therapy (HAART)
- Linkage between PMTCT and ART services will improve.
- Mother-baby pair follow-up system is established.
- Rapid testing and PCR will cover 95% of antenatal clinics by 2010.

Obstacles and Solutions

The following obstacles and solutions were proposed. Please note that the list is not exhaustive:

Obstacles	Proposed Solutions
Limited human resources	Revise staff establishment structures and fill vacant positions
There is an overall shortage of health workers and lack of health workers trained in the latest PMTCT guidelines	Scale up training on PMTCT, early infant diagnosis, integration of services
Limited infrastructure	Develop a costed plan for renovation and expansion of facilities
There is a lack of space in facilities, including laboratory capacity for rapid testing. Furthermore, there is limited access to services.	Expand and strengthen outreach to maternal and child health services
Lack of an integrated system for maternal and child health data	Develop integrated maternal and child health information system
Insufficient community mobilization on reproductive health, including PMTCT	Develop community mobilisation strategy integrated with COMBI
Lack of clarification of legislation allowing storage and dispensing of ARV medicines	Guidelines and policy developed and implemented
Poor partner involvement	Develop a strategy for mobilizing and increasing male involvement
Untimely and incomplete reporting	Strengthen the HIS system such as improving communication systems, strengthen and build capacity of the health workers and data entry clerks
Lack of operationalisation of guidelines and policies	Development, finalization of the guidelines and implementation
Lack of family planning counselling	Develop IEC material and job aids on family planning and build capacity, establish linkages between ANC, Maternity, postnatal ward and ART sites

3.3. COUNSELLING & TESTING (C&T)

The counselling and testing programmes have made good progress. The number of persons tested is increasing each year. Testing points can be found at public sector hospitals and in many clinics, plus the private sector. The introduction in 2005 and use of rapid testing has improved the efficiency of health service personnel, providing quicker test results to the client has proven to be more cost efficient. Furthermore, it has reduced non-return rates (clients not returning for their test results) from a monthly high of 13 percent to below 2 percent in New Start sites.

Indicator Matrix

Programme Indicators	2000-03	2006/07	2009/10	2011/12	2014/15
Number of testing and counseling sites	NA	270	329	341	360
National Indicator	2000-03	2006/07	2009/10	2011/12	2014/15
Percent of women and men aged 15-49 reporting that they were tested for HIV and received the results in the past 12 months	NA	M 18% W 29%	M 22% W 35%	M 28% W 41%	M 34% W 47%

Assumptions

The targets set are based on the following assumptions:

- The private sector health facilities are not included in the targets.
- Availability of services, particularly the roll-out of Rapid Testing (RT) continues to scale up.
- More men will turn up for C&T if social mobilization is successful and there is leadership involvement.
- There is availability of adequate staffing (quantity and quality human resources) for the programme
- Counselling is included as part of the testing service as per the national guidelines.
- Counselling takes place and is of high quality.
- Training and roll-out will take place.

Obstacles and Solutions

The following obstacles and solutions were proposed. Please note that the list is not exhaustive:

Obstacles	Proposed Solutions
Limited success of social mobilization due to lack of male involvement	Promote male involvement
Stigma and discrimination	
Inadequate resources (Human)	Source additional funds to help address human capacity needs.
Poor coordination	
Limited infrastructure	Source additional funds to help address infrastructure issues.
Private sector not following national guidelines and reporting data	Get medical aid to ensure that private sector abides by national guidelines for quality assurance and data reporting
Limited consent to testing	
Better access for rural communities to testing facilities	Mobile testing needs to be rolled out to address rural underserved communities
High financial cost	Review rigid guidelines for RT certification. This will enable more rapid roll-out of RT and ensure that quality is maintained.

3.4. STI'S, CONDOMS, AND REPRODUCTIVE HEALTH

Ensuring that HIV prevention and referral to services are included in reproductive health will enhance the HIV response. Sexually transmitted infections continue to pose a major health challenge in Namibia. Failure to adequately diagnose and treat STI's has contributed to complications and increased HIV infection rate.

The MoHSS has achieved remarkable success in facilitating the process that the use of condoms can be openly discussed, talked about and promoted within all segments of the population. Tracking condom supplies and channeling from regional medical stores to health facilities and from health facilities to the communities (users) remains a major challenge. Currently it is not known if the demand in the communities and rural areas is met.

Indicator Matrix

Programme indicators	2000-03	2006/07	2009/10	2011/12	2014/15
Number of condoms distributed (male and female)	9.4 million	28.5 million	35 million	42 million	50 million
Number of clients treated for Urethrad discharge syndrome (UDS) in the public sector	~18,000	~17,000	13600	10880	8700
National indicator	2000-03	2006/07	2009/10	2011/12	2014/15
Percentage of women and men aged 15-49 who had multiple partners in the past 12 months who reported using a condom the last time they had sex	NA	W 66% M 74%	W 71% M 79%	W 76% M 84%	W 81% M 89%

Assumptions

The targets set are based on the following assumptions:

- Data collection from private sector will improve.
- Condom counts and distribution are proxies for use.
- Condom use will continue to be promoted and distribution of condoms to rural areas will be ensured.
- Successful IEC/BCC campaigns will take place.
- STI syndromic management guidelines will be periodically updated as needed with accompanying training modules.
- The limitations of self reported data and the need to ensure a consistent data collection method are recognised.
- Condom messages will be consistent and will encourage use with all partners
- There is adequate funding and staffing.

Obstacles and Solutions

The following obstacles and solutions were proposed. Please note that the list is not exhaustive:

Obstacles	Proposed Solutions
Female condom acceptability, accessibility, cost and marketing	Finding out exactly where distribution and promotion gaps occur in order to address them
Not coordinated services between condoms, STIs and reproductive health	
Not measuring consistency of condom use	Conduct impact assessment to understand condom use
Condom accessibility (in remote areas) is limited due to poor distribution systems and high transportation costs	Strengthen outreach for condom distribution
Cultural beliefs	Address the root causes of lack of condom use: women not empowered to make decision to use condoms
Training for STI service providers	
Substance abuse (drug, alcohol)	Conduct more targeted interventions (men, women, youth, etc)
Budget constraints	Seek funding
Difficulty in data collection from private sector for STI information	

3.5. BLOOD SAFETY, PEP, MEDICAL INJECTIONS

Prevention of transmission within health facilities is guided by the MoHSS National Guidelines on Post Exposure Prophylaxis (PEP). The guidelines and set procedures for universal precaution for transmission of Hepatitis (B and C), HIV etc and include procedures for PEP. The Division of Occupational Health and Safety (Directorate of Primary Health Care (PHC), has developed the National Occupational Health Policy (July 2006). The MoHSS also supports the implementation of injection safety efforts and has developed regional waste management guidelines. Local manufacture of sharp containers is underway and MoHSS will take over responsibility of supplying disposal containers. It is envisaged that the waste management programme will be scaled up and critical training of health workers in safe injection and waste management practices continued. Initiation of private health care providers in injection safety dissemination meetings have started.

Indicator Matrix

Programme indicator	2000-03	2006/07	2009/10	2011/12	2014/15
Average number of medical injections per person in the past 12 months	NA	M 3.1 W 2.8	M 2.7 W 2.5	M 2.5 W 2.0	M 1.0 W 1.0
Percent of facilities where unexpired PEP kits are available at the time of survey	NA	NA	80%	90%	100%
Percent of facilities where PEP guidelines are available	NA	NA	80%	90%	100%
Percent of donated blood units screened for blood borne pathogens in a quality assured manner	NA	NA	100%	100%	100%

Assumptions

The targets set are based on the following assumptions:

- PEP kit contents will be defined for both occupational and non occupational events.
- Registers of PEP kits exist in the hospitals.
- Functioning incinerators exist in all hospitals.
- Colour-coded bags and appropriate transport systems are available.
- Human and financial resources are available.

Obstacles and Solutions

The following obstacles were proposed. Please note that the list is not exhaustive. Due to time constraints no solutions were put forward.

- Lack of funding.
- Lack of a developed PEP program.
- Lack of skilled human resources.
- Lack of a good reporting system.

3.6. PREVENTION AMONG VULNERABLE GROUPS

There has been an increased focus on vulnerable groups with comprehensive programmes implemented in the National Defence Force, the police and to a limited extent in prisons. Interventions targeting commercial sex workers, truck drivers, mobile populations, and men having sex with men (MSM) are still limited in scale and scope and need further emphasis to prevent the spread of HIV especially as small surveys indicate high prevalence. The MTP III Mid Term Review report (July, 2007) states that the lack of deeper understanding of how the epidemic spreads in Namibia and the driving factors behind localised epidemics make it hard to establish who is most vulnerable to HIV. This also makes it hard to determine through which strategy HIV incidence could most effectively be reduced.

Indicator Matrix

Programme Indicators	2000-03	2006/07	2009/10	2011/12	2014/15
Number of sex workers reached with comprehensive HIV and STI services	NA	150	3000	6000	8000
Percent of prisoners who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	NA	NA	60%	75%	90%
Among men who have sex with men and who had more than one partner in the past six months, the percent who used a condom at last sex	NA	NA	75%	80%	90%
National Indicator	2000-03	2006/07	2009/10	2011/12	2014/15
HIV prevalence among sex workers	NA	NA (70% in Katutura)	60%	55%	40%

Assumptions

The targets set are based on the following assumptions:

- Regular behavioural and impact surveys are conducted among sex workers, MSM and prisoners.
- Sex workers have access to HIV and STI reduction services in their communities.
- Interventions for people living with HIV are covered under other categories (ARV, PMTCT and prevention in the general population).
- Vulnerable groups are being targeted with peer education interventions.
- Resources are available.
- Political will exists to target vulnerable groups.
- Government and civil society have capacity to target vulnerable groups.

Obstacles and Solutions

The following obstacles and solutions were proposed. Please note that the list is not exhaustive:

Obstacles	Proposed Solutions
There is currently no systematic data collection about vulnerable populations	Systematise behavioural surveillance to avoid periodically/ routinely collected data relying on a single proxy
Difficult to document HIV prevalence among vulnerable groups as these groups are often hard to identify (sex workers, MSM)	It is difficult to identify the target population (sex workers) so work through peer community research to gain access to these populations
Prisoners only tested when sick, no testing offered to entire population on regular basis	
Condoms are not distributed (sex is illegal) in prisons	
No information available on Injecting Drug Users (IDU) regarding size of group and risk behaviours	Seeking funding for research/interventions
Current MSM programs only target self-identified MSM	
Lack of a conducive legal environment; legal framework criminalizes sex workers and MSM	Advocate to change policy that criminalizes these vulnerable populations
National target only includes female sex workers there are no men in the data collection method so no reporting is done on ALL sex workers, but only on a proxy of female sex workers	Once groups are identified, comprehensive tailored interventions implemented with these groups needs to be done.

3.7. PREVENTION AMONG GENERAL POPULATION

Prevention of the transmission of HIV remains the cornerstone of the strategy to overcome the epidemic. In the MTP III, the prevention component is based on processes that influence attitudes to create intentions to change behaviour. The social mobilization has been an integral part of the HIV strategies since the early 1990s.

Indicator Matrix

Programme indicator	2000-03	2006/07	2009/10	2011/12	2014/15
Percent of young women and men 15-19 who had sex before the age of 15	W 9.8% M 31.3% 2000	W 7.4% M 19.2%	W 6% M 15%	W 5% M 12%	W 4% M 10%
National indicators	2000-03	2006/07	2009/10	2011/12	2014/15
Percentage of women and men aged 15-49 who had sex with more than one partner in the last 12 months of those who are sexually active	W 3% M 22% (2000)	W 2.5% M 16.1%	W 1% M 13%	W 1% M 10%	W 1% M 5%
Number of safe male circumcisions that have been performed in the last 12 months in medical facilities	NA	to be determined after situation assessment			
HIV prevalence among women and men ages 15-24	NA 2002 17.9% (ANC)	NA 2006 14.2% (ANC)	12%	10%	5%

Assumptions

The targets set are based on the following assumptions:

- An interim AIDS Indicator Survey will be done in 2009 and will include behavioural surveillance.
- There will be rapid roll-out for male circumcision services.
- There is renewed commitment by high level officials towards prevention.
- Enforcement of alcohol policies are in place.
- There is successful communication around male circumcision (not resulting in increased risk behaviour).

Obstacles and Solutions

The following obstacles and solutions were proposed. Please note that the list is not exhaustive:

Obstacles	Proposed Solutions
Insufficient data	MC indicator can be collected in the situational analysis
Challenges to measuring risky behaviours	Propose better concurrency indicator to DHS based on multiple concurrent definition
Limited access to condoms in rural area	
Lack of education/knowledge around correct condom use	
Lack of cultural acceptance of male circumcision	Certified traditional circumcisers conducting MC report to the national data
Data coming from private hospitals and clinics does not feed into the nationally reported data	Improve coordination between Medical Aid and private sector facilities in order to establish a reporting system that feeds data from the private sector to national level. (Perhaps request Clinicians Society for assistance with this).
Cultural desirability to have children limits condom use among young women	
Social and cultural norms around alcohol/concurrent partners	

Other Issues

Prevention among young people falls within the general population response; however with the new data and statistics available it is evident that young people between the ages of 15 and 24 are both the most threatened and the greatest hope for turning the tide against HIV. Gender disaggregated data shows an increased level of HIV infection among girls in this age group. Although HIV continues to be the single most important development challenge for Namibia, sustained interventions aimed at youth have been found to have a measurable impact, hence this warrants for separate and well thought out targets and innovative responses. Future target setting exercises will include targets specifically for young people.

Prevention among people living with HIV is also an important component to any prevention strategy. However, multiple strategies address this issue by working with people living with HIV to reduce new infections (such as through PMTCT counselling, or ARV counselling). Since this is covered in other areas no target was included.

Namibia is currently conducting a situation assessment on male circumcision and has not yet implemented a male circumcision policy or strategy. The Minister of Health and Social Services made it clear to parliament last year that such a strategy would be rolled out. In the final session of the target setting workshop it was decided that a male circumcision indicator would be included among the national indicators to monitor this important prevention initiative. Since the goal of any future policy will be to increase safe male circumcision only those circumcision conducted in health facilities will be counted in this indicator (at this point in time).

3.8. ORPHANS VULNERABLE CHILDREN (OVC)

Within the Ministry of Gender Equity and Child Welfare (MGEWCW) the division of child welfare was established and social workers were appointed in all regions. The OVC policy has been adopted and published in February 2005 and a national plan of action (NPA) was drafted and finalised in 2007, which includes a monitoring and evaluation plan. The NPA includes a five year strategic plan on rights and protection, education, health and nutrition, care and support services and mobilisation, integration and networking. The systems for direct support to OVCs and affected families are in place and an increased number of OVC are benefiting from grants, food and other support schemes. It is important to note that there is substantial efforts coming from civil society to support children and their caretakers. In order to improve the management and monitoring of grants and support, an OVC database has been developed, but is yet to be implemented.

Indicator Matrix

Programme indicators	2000-03	2006/07	2009/10	2011/12	2014/15
Number of children receiving welfare grants	NA	65,000	130,000	150,000	170,000
Ratio of OVC to non-OVC aged 0-4 who are underweight	NA	1.31	1.15	1.05	1.0
Ratio of OVC to non-OVC aged 15-17 who completed grade 10	NA	To be calculated	0.8	0.9	1.0
National indicator	2000-03	2006/07	2009/10	2011/12	2014/15
Percentage of orphans and vulnerable children whose households receive at least one type of free basic external support in caring for the child	2000 NA	2006 16.5%	35%	50%	65%*

* A concern was raised after the targets setting process that this was not an ambitious enough target. The target will be monitored and adjusted as needed.

Assumptions

The targets set are based on the following assumptions:

- There are limitations to the current definition of vulnerability.
- Children's Act of 1960 will be reviewed and modified.
- Child care workers will be in place at the constituency level.
- Finances are made available for social grants.
- The numbers of orphans and vulnerable children will plateau as ART programmes roll out, reducing mortality among parents.
- Data collection regarding the external support provided in national surveys will be improved.
- MGECW database will be operating and provide necessary information.
- There is a common understanding of services and vulnerability (standards).
- Funding continues at current and increased levels.

Obstacles and Solutions

The following obstacles and solutions were proposed. Please note that the list is not exhaustive:

Obstacles	Proposed Solutions
Difficulty in determining the appropriate response for vulnerable children	
Difficulties in getting birth and death certificates	Decentralise birth/death certificate system to constituency level
	Conduct informational sessions for parents on value of and need for birth/death certificate or include in existing outreach programmes
Lack of capacity of community based organisations to scale up and coordinate	Strengthen referral systems between health/education facilities and OVC services
Insufficient social workers or equivalent staff to identify and process children in need of grants	Fund (and provide technical support to) constituent level OVC forums for networking and capacity building
Insufficient number of magistrates to process foster grants	Improve the capacity of magistrates to process child custodian cases

3.9. HOME BASED CARE (HBC)

Home based care provides a continuum of care for the chronically ill and PLWHA in their home environment. It provides services in a cost effective, sustainable and comprehensive manner, in a complementary approach to institutional care. Apart from providing care and support to clients/patients, the HBC programmes also seek to enhance or build the capacity of clients' families to offer affordable, quality care for their relatives. Most HBC in Namibia is provided by community based organizations or large NGOs (such as Red Cross or Catholic AIDS Action).

Indicator Matrix

Programme indicators	2000-03	2006/07	2009/10	2011/12	2014/15
Number of active HBC volunteers registered with main HBC providers and providing HBC services throughout the year	9615 (2005)	9300	9535	10235	11835
Number of clients served according to the standard in two categories of care by registered HBC volunteers (categories include: 1. Preventative care and health promotion, 2. Home nursing and treatment adherence, 3. Emotional, psychological, and spiritual support, and 4. Social legal and livelihood support)	NA	NA	NA	NA	NA

Assumptions

The targets set are based on the following assumptions:

- Regional Aids Coordinating Committees (RACOCs) have the capacity to complete their role in data collection and dissemination.
- MOHSS Regional Health Directorate specifically the Family Health Division has capacity to coordinate all HBC activities in regions.
- All HBC providers are following the national standards as well as reporting to government.
- The synthesis of HBC/palliative care services is completed as it is one package of services.
- Clients and families are all registered clients and their families/caregivers.
- An individual counted as a registered HBC provider means that they also receive HBC kits replenished quarterly in the previous 12 months.
- An individual counted as a HBC provider will receive training as approved by the MOHSS to be considered as such.
- HBC care providers cover more chronically ill individuals than HIV positive individuals.
- On average one HBC volunteer will have three clients to provide services to depending on the level of care required.
- Funding will continue/scale up over the targeted years.
- Government will contribute resources/funding to HBC.

Obstacles

The following obstacles were identified in reaching these targets.

Obstacle	Solution
Data on clients with other terminable diseases (i.e. cancer) is not readily accessible	Put mechanisms in place on working with oncology unit
Lack of consistent reporting by non governmental organisations and other service providers	MoHSS (Family Health) to actively take leading coordinating role of HBC activities, activate or establish the HBC regional forums (sub-committees of RACOC)
No minimum standards of care	Development of standards in progress
Lack of accounting for double counting in reporting	Work with monitoring and evaluation (DSP) sub-division to develop monitoring tools
Attrition of trained HBC volunteers	Accreditation of HBC training and provision of incentives whether in monetary or in kind.
Lack of incentives for volunteers	Government and HBC organization meet and look into the long term solution and agreement to this issue.

3.10. WORK PLACE PROGRAMMES (WPP)

In 2006 all of the all 27 Government Offices, Ministries or Agencies (OMAs) were trained on developing work place programmes. However, due to a lack of human resources few OMAs have implemented these programmes. In the private sector the Legal Assistance Centre has been supporting development of policies, but it is still not known what percentage of larger corporations, smaller and medium enterprises have developed HIV/AIDS workplace policies. In addition there has been little activity to establish workplace programmes in civil society.

Indicator Matrix

No national indicator was listed.

Programme indicators	2000-03	2006/07	2009/10	2011/12	2014/15
Number of OMAs implementing a comprehensive HIV/AIDS workplace programme with a budget	NA	3/28	14/28	20/28	24/28
Number of medium and large enterprises implementing a comprehensive HIV/AIDS work place programme with a budget	NA	50/5500	100/5500	150/5500	200/5500

Note: An indicator and targets for small enterprises were excluded because they were not possible to measure.

Assumptions

The targets set are based on the following assumptions:

- Medium to large have a comprehensive WPP consisting of: policy, plan & budget, active committee, a focal person, peer education, prevention activities, care & support, a referral system and M&E component.
- Companies have plans and budgets in place.
- More human resources will be provided to OPM to implement and monitor WPP.

There is continued support for capacity building.

Obstacles and Solutions

The following obstacles were identified to reaching these targets.

For the public sector

- Temporary nature and mobility of focal persons and committee members makes it difficult to maintain programmes; Focal persons are on the move to other ministries and often work part-time.
- Lack of office space for focal persons to execute their work.
- Lack of available funds through the budget process.
- Lack of commitment from senior and middle managers with regards to implementation of work place programmes.
- Low capacity absorption, in other words lack of enrolment of employees in the workplace programmes.

For the private sector:

- M&E plans from private sector are currently not in place.
- There are no dedicated full-time wellness managers (added on the current jobs and there is no incentive for them).
- Lack of commitment from senior and middle managers with regards to implementation.

3.11. GOVERNANCE AND MAINSTREAMING

The section on the enabling environment in the MTP III is set out to facilitate the implementation of interventions and activities that lead to the attainment of an environment where the rights of PLWHA are realised and respected. The expected result is that "the people infected and affected with HIV/AIDS enjoy equal rights in a culture of acceptance, openness and compassion". The Mid Term Review report (July, 2007), states that a high level of activities have been identified. However stakeholders are struggling with the difficulty of designing and implementing effective strategies that address the main problem areas, and finding efficient systems to address the challenges.

Indicator Matrix

Programme indicators	2000-03	2006/07	2009/10	2011/12	2014/15
Percent of OMAs implementing an HIV and AIDS plan and budget (mainstreaming)	NA	5	15	20	25
Percent of government funding committed to Health	11	NA	13%	14%	15%
National indicators	2000-03	2006/07	2009/10	2011/12	2014/15
Percent of national coordination bodies (NAC/NAMACOC /NAEC) scheduled meetings held per year with quorum	NA	NA	90%	95%	95%
Percent of regional coordination bodies (RACOC/ CACOC) implementing an HIV and AIDS plan and budget (mainstreaming)	NA	R 77% C 54%	R 85% C 65%	R 95% C 75%	R 100% C 85%
Percent of GRN funds spent on HIV out of total HIV expenditure	?	51%	55%	60%	65%
Percent of women and men 15-49 expressing accepting attitudes on 4 questions about HIV	NA	W 39% M 36%	W 50% M 44%	W 60% M 50%	W 70% M 60%

Assumptions

The targets set are based on the following assumptions:

- There is availability of documentation to measure indicators
- Roles of key stakeholders (OPM/NPC/MoHSS) are clarified
- Planning and budgeting cycles for HIV and AIDS and OMAs strategic plans are harmonized
- Human and financial resources for implementation and data collection are in place.
- Data on expenditure is available and shared from all relevant stakeholders (surveys available for private sectors and civil society).
- Increased involvement of national, regional and community leaders in the response.
- There is better understanding amongst senior management in all sectors of HIV issues as a crucial cross-cutting development issue.
- Information on HIV reaches all levels of society.

Obstacles and Solutions

The following obstacles and solutions were proposed. Please note that the list is not exhaustive:

Identified obstacles	Proposed Solutions
Challenges with coordination and lack of agency in addressing HIV	Integrate HIV/AIDS in development and management agenda's and strengthen coordination
Inadequate human capacity & quantity and financial resources for implementation	Scale up recruitment, training and development for management and coordination levels
Lack of clarity of roles, responsibilities and accountability structures	
Weak multi-sectoral communication and coordination	OPM has to allocate more national resources and strengthen absorption capacity
Few, misconceptions and lack of openness towards HIV/AIDS	Ensure aligned and targeted B/C and BC messages with consistent and controlled messaging
Weak harmonization of health interventions	

3.12 TUBERCULOSIS (TB)

The GRN has clearly demonstrated that it is committed to controlling and eliminating TB by 2015. The Annual Report on The National TB and Leprosy Control Programme (2006) states that 15,771 tuberculosis cases were reported in 2006. Namibia has the second highest case notification rate in the world, after Swaziland. The epidemic is declining despite the high levels. Since 2005 slight improvements in the treatment success rate for new smear positive TB cases have been achieved but these results are still below the national and global target of 85 percent.

Indicator Matrix

Programme Indicator	2000-03	2006/07	2009/10	2011/12	2014/15
Percentage of TB patients with known HIV status	NA	30%	80%	90%	95%
National Indicator	2000-03	2006/07	2009/10	2011/12	2014/15
TB treatment success rate	68%	75%	80%	85%	90%

Assumptions

The targets set are based on the following assumptions:

- Funds will be made available by government to continue scale up efforts after the end of external funding.
- Government will review the staff establishment to priorities TB for human resource allocation.
- NIP and MOHSS will work together on new XDR/MDR testing policy.
- NGOs working in DOTS will report the registers.

Obstacles and Solutions

The following obstacles and solutions were proposed. Please note that the list is not exhaustive:

Obstacles	Proposed Solutions
Stigma	Accelerate implementation of TB communication behaviour initiative (COMBI) to address patient education and stigma
Geographic in-accessibility to TB services	Expand community DOTS to all 13 regions
Inadequate involvement of other stakeholders	Strengthen public private partnerships to improve diagnosis and treatment
Coordination between programme and DSP, Response Monitoring & Evaluation subdivision	Designate TB/HIV focal person in Ministry
Lack of coordination between TB and HIV programme- both national and local	
Increased rates of TB due to high prevalence of HIV in the country TB/HIV	
Human resources (quality and quantity); Insufficient and lack of qualified personnel	
Lack of definition of who is eligible for and coverage of DOTS	
Lack of space for inpatients/infection control	

4. CONCLUSIONS & RECOMMENDATIONS

An important milestone in Namibia's national planning process for HIV and TB has been achieved during a four-day workshop. The achievement is evidence that the country is determined to scale up its HIV and TB interventions. Furthermore, it shows that government, civil society, the private sector, faith-based organisations and development partners are able to engage in a process of collaborative decision-making in the area of HIV and TB.

It is also clear that with the achievement reached the process of striving for universal access for prevention, treatment, care, and support of HIV/AIDS and TB services in Namibia, has made a crucial step forward.

The level of the county's accountability is strengthened in view of both national and international commitments made and this will facilitate (sector) planning and international resource mobilization for specific interventions. The efforts made will also focus stakeholders on specific targets and facilitate the development process of the next strategic frameworks (MTP IV for HIV and MTP II for TB) and the Round 8 application for the Global Fund.

Much of the success of the workshops' consensus building can be ascribed to the good turn-out of over 100 stakeholders in the field of HIV and TB. The participants exhibited active participation and were committed to reaching consensus throughout the process. The support provided by both the programme facilitators and M&E officers during the group discussions played an important role in ensuring consensus on the indicators and targets. Moreover, the clearly outlined methodology and the provision of various sources of documentation and information were also very useful during the small group exercises and contributed to the workshop's effectiveness.

Among the most frequently listed assumptions underlying the target-setting process are: continued financial funding from government and development partners; availability of infrastructure and other resources; improved data collection and harmonised M&E reporting systems; availability of human resources both in terms of quality and quantity.

Some of the reported obstacles that may hamper the achievement of targets in prevention are: lack of coordination and lack of male involvement. In the area of care and treatment it is predominantly lack of skilled human resources and lack of access to services particularly in rural areas. Core obstacles in the area of management and enabling environment are mainly lack of human resources (both quality and quantity) and budgetary constraints. Challenges remain coordinating the response and the lack of urgency in the national efforts to address the HIV and TB epidemics.

The following recommendations were made to ensure consistent and accurate measurement of the targets:

- A nationally representative survey including HIV testing is critical for improving Namibia's measure of HIV prevalence.
- The main challenge in Namibia is the prevention of new and secondary infections, which requires consistent measures of behaviour change. Thus, more frequent nationally representative surveys are needed to measure progress.
- It is important to avoid small scale Knowledge Attitude and Practices (KAP) surveys, and rather utilise funds for nationally representative, high quality surveys. This requires a coordinated execution of the M&E plan.
- Surveys for key vulnerable groups (sex workers, men who have sex with men, prisoners) are particularly needed.
- It is important to ensure that more consistency for future programme data reporting is guaranteed.
- Quality assurance checks should be put in place to ensure a high level of confidence in the accuracy of the data being reported and used for programme planning.

The targets were presented and approved by the National Aids Executive Commission (NAEC) on 27 February 2008. In addition the report was presented for review to the National Multi-sectoral AIDS Coordinating Committee (NAMACOC) in March 2008.

The targets developed will be fed into important processes such as: the development of MTP IV (HIV/AIDS) and MTP II (TB); the Round 8 Global Fund application and other resource mobilisation efforts, sectoral planning processes and annual work planning of all stakeholders (government, civil society partners and development partners).

ANNEX 1: NATIONAL LEVEL INDICATORS

Projections on the number of people in need of ARTs, number of women in need of PMCT, number of people living with HIV, were only available through 2012. The model is not able to project past 3 years from the most recent data (2008 HIV Sentinel Surveillance).

Indicator Name	Numerator	Denominator	Frequency	2006-2007	2008-09	2009-10	2010-11	2011-12	2012-13	Source
Prevalence										
100 prevalence among women and men ages 15-49	Number of HIV positive women and men ages 15-49 sampled in survey	Number of men and women 15-49 sampled in survey	Annual	NA 17.0% (2007 ABC)	NA 16.2% (2008 ABC)	1.1%	1.1%	1.1%	1.1%	UNAIDS
Percent of women and men aged 15-49 reporting that they were tested for HIV and learned the results in the past 12 months	Number of women and men aged 15-49 tested for HIV and received results in past 12 months	Number of women and men ages 15-49 surveyed	Every 3 years	NA	W: 10% M: 20%	M: 22% W: 20%	M: 20% W: 20%	M: 20% W: 20%	M: 20% W: 20%	UNAIDS
Percentage of women and men aged 15-49 who had multiple partners in the past 12 months who reported using a condom at last sex	Number of women and men aged 15-49 who reported using a condom the last time they had sex	Number of men and women aged 15-49 who reported having multiple partners in the past 12 months	Every 3 years	NA	W: 30% M: 14%	W: 11% M: 7%	W: 11% M: 4%	W: 11% M: 4%	W: 11% M: 4%	UNAIDS
100 prevalence among men without sexually transmitted infections	Number of men without reporting consistent condom use in past month	Number of men without surveyed	Every 3 years	NA	NA (70% in Suburban)	80%	80%	80%	80%	Behavioral surveillance
Percent of women and men aged 15-49 who had sex with more than one partner in the last 12 months of those who are sexually active	Number of women and men aged 15-49 who had sex with more than one partner in the last 12 months	Number of women and men ages 15-49 who had sex in the last 12 months	Every 3 years	W: 2% M: 27% (2007)	W: 2.5% M: 16.1%	W: 1% M: 13%	W: 1% M: 10%	W: 1% M: 10%	W: 1% M: 10%	UNAIDS
Number of safe abortions that have been performed in the last 12 months in medical facilities	NA (Note this refers only to legal abortions being performed in medical facilities)	NA	Annual	NA	NA	NA	NA	NA	NA	NA

Indicator Name	Indicator	Denominator	Frequency	2000-2001	2004/5	2005/6	2006/7	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	Source
Treatment, Care and Support Services																	
Percent pregnant HIV women receiving a complete course of ART	Number of women receiving ART	Number of women identified as HIV in tertiary	Annual	8%	6%	6%	6%	7%	6%	6%	6%	6%	6%	6%	6%	6%	HR, ARTCT and facilities
Percent of adults and children (0-14) with advanced HIV infection receiving ART	Number of adults and children (0-14) receiving ART	Estimated number of adults and children (0-14) in need of ART	Annual	A 30% C 60%	A 30% C 60%	A 30% C 60%	A 30% C 60%	A 30% C 60%	A 30% C 60%	A 30% C 60%	A 30% C 60%	A 30% C 60%	A 30% C 60%	A 30% C 60%	A 30% C 60%	A 30% C 60%	HR, ARTCT and facilities
TB treatment success rate	Number of new smear positive TB patients cured and those that have completed treatment successfully	Total number of all patients enrolled for previous year	Annual	60%	70%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	DRUGS
Percent of exposed and vulnerable children whose households receive at least one type of free basic external support in caring for the child	Number of OVC whose households received free basic external support to care for the child	Number of OVC ages 0-17	Every 3 years	6%	10-60%	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%	DRUGS
Management and Funding Mechanisms																	
Percent of national coordination bodies (NAC, ApACOC, SACOC) scheduled meetings held per year with representative groups	Number of meetings that met quarterly	Number of NAC, ApACOC, SACOC meetings held	Annual	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%	Management records
Percent of regional coordination bodies (RACOC, CACOC) implementing a risk and ACS plan and budget	Number of coordination bodies implementing risk register and budget	Number of coordination bodies (10/100)	Annual	6%	6-10%	6-10%	6-10%	6-10%	6-10%	6-10%	6-10%	6-10%	6-10%	6-10%	6-10%	6-10%	System for Programme Monitoring
Percent of SAC, local spent on HIV out of total HIV expenditure	Government expenditure on HIV SAC	Total HIV expenditure in year	Annual	6%	1%	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%	Ministry of Finance
Percent of women and men (0-49) reporting accepting attitudes in females about HIV	Number of women and men (0-49) reporting accepting attitudes in females about HIV	Number of women and men (0-49) surveyed	Every 3 years	6%	6-30%	6-30%	6-30%	6-30%	6-30%	6-30%	6-30%	6-30%	6-30%	6-30%	6-30%	6-30%	DRUGS

ANNEX 2: PROGRAMME LEVEL INDICATORS

	Numerator	Denominator	Frequency	2006-08	2009-11	2010-12	2011-13	2014-15	Score
Antiretroviral Therapy									
Percent of adults and children (0-14) with advanced HIV infection receiving ART	Number of adults and children (0-14) receiving ART	Estimated number of adults and children (0-14) in need of ART	Annual	A 75% C 25%	A 80% C 60%	A 80% C 60%	A 80% C 60%	A 80% C 60%	100 (ARV) and Spectrum estimates
Percent of adults and children (0-14) with HIV still alive at 12 months after initiation of antiretroviral therapy	Number of adults and children (0-14) still alive 12 months after starting ART	Number of adults and children (0-14) starting on ART 0-23 months earlier	Annual	NA	A 80% C 60%	A 80% C 60%	A 80% C 60%	A 80% C 60%	DM and PMU
PEP/CT									
Percent pregnant HIV+ women receiving a complete course of ART prophylaxis	Number of women receiving ARTs	Number of women identified as HIV+ at delivery	Annual	70%	70%	80%	80%	80%	100 PEP/CT and Spectrum
Percent of pregnant women attending for ANC, still alive, received complete ARTs	Number of women receiving ARTs	Number of women attending ANC	Annual	70%	70%	80%	80%	80%	100 PEP/CT
Percent HIV+ exposed infants receiving Cotrimoxazole within 8 weeks of birth	Number of infants tested through PCR within 8 weeks of delivery	Estimated number of births to HIV+ women (PCR exposed infants)	Annual	70%	70%	80%	80%	80%	PCR and Spectrum
Counseling and Testing									
Percent of men and women aged 15-49 who rapid testing tested for HIV and receiving their results in last 12 months	Number of people reporting they were tested and received their results	Number of men and women in the survey	Annual	NA	M 20% W 20%	M 20% W 40%	M 30% W 40%	M 30% W 40%	Demographic
Number of testing and counseling sites	NA (Combined new start and (90% sites)	NA	Annual	NA	270	341	360	360	MARDI

	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
18% Contraception and Reproductive Health									
Number of condoms distributed (male and female)	NA	NA	NA	28.8 million	28 million	42 million	50 million	50 million	50 million
Number of clients trained for LARs in the public sector	NA	~2,000	~11,000	6,000	1,000	1,000	1,000	1,000	1,000
Percentage of women and men aged 15-49 who had multiple partners in the past 12 months who reported using a condom the last time they had sex	NA	NA	NA	65%	67%	67%	67%	67%	67%
Blood Safety, HIV, Malaria Infections									
Average number of medical specimens per person in the past 12 months	NA	NA	NA	W 2.8	W 2.8	W 2.8	W 2.8	W 2.8	W 2.8
Percent of facilities where serology HIV tests are available at the time of service	NA	NA	NA	NA	8%	8%	8%	8%	8%
Percent of facilities where HIV guidelines are available	NA	NA	NA	NA	NA	NA	NA	NA	NA
Percent of donated blood units screened for blood borne pathogens in a fully automated manner	NA	NA	NA	100%	100%	100%	100%	100%	100%
Number of men and women aged 15-49 who reported having multiple partners in the past 12 months	NA	NA	NA	6,000	6,000	6,000	6,000	6,000	6,000
Number of men and women aged 15-49 who reported having multiple partners in the past 12 months who had multiple partners in past 12 months	NA	NA	NA	6,000	6,000	6,000	6,000	6,000	6,000
Number of medical specimens given	NA	NA	NA	W 2.8	W 2.8	W 2.8	W 2.8	W 2.8	W 2.8
Number of facilities with unexpired HIV tests available	NA	NA	NA	NA	8%	8%	8%	8%	8%
Number of facilities with HIV guidelines available	NA	NA	NA	NA	NA	NA	NA	NA	NA
Number of blood units screened	NA	NA	NA	100%	100%	100%	100%	100%	100%
Number of blood units submitted for screening	NA	NA	NA	100%	100%	100%	100%	100%	100%
Number of men and women aged 15-49 who reported having multiple partners in the past 12 months	NA	NA	NA	6,000	6,000	6,000	6,000	6,000	6,000
Number of men and women aged 15-49 who reported having multiple partners in the past 12 months who had multiple partners in past 12 months	NA	NA	NA	6,000	6,000	6,000	6,000	6,000	6,000
Number of medical specimens given	NA	NA	NA	W 2.8	W 2.8	W 2.8	W 2.8	W 2.8	W 2.8
Number of facilities with unexpired HIV tests available	NA	NA	NA	NA	8%	8%	8%	8%	8%
Number of facilities with HIV guidelines available	NA	NA	NA	NA	NA	NA	NA	NA	NA
Number of blood units screened	NA	NA	NA	100%	100%	100%	100%	100%	100%
Number of blood units submitted for screening	NA	NA	NA	100%	100%	100%	100%	100%	100%
Number of men and women aged 15-49 who reported having multiple partners in the past 12 months	NA	NA	NA	6,000	6,000	6,000	6,000	6,000	6,000
Number of men and women aged 15-49 who reported having multiple partners in the past 12 months who had multiple partners in past 12 months	NA	NA	NA	6,000	6,000	6,000	6,000	6,000	6,000
Number of medical specimens given	NA	NA	NA	W 2.8	W 2.8	W 2.8	W 2.8	W 2.8	W 2.8
Number of facilities with unexpired HIV tests available	NA	NA	NA	NA	8%	8%	8%	8%	8%
Number of facilities with HIV guidelines available	NA	NA	NA	NA	NA	NA	NA	NA	NA
Number of blood units screened	NA	NA	NA	100%	100%	100%	100%	100%	100%
Number of blood units submitted for screening	NA	NA	NA	100%	100%	100%	100%	100%	100%

	Baseline	December	Frequency	2004-05	2005-07	2006-10	2011-12	2014-17	Source
Prevention among vulnerable groups									
Number of sex workers reached with comprehensive STI services	NA	NA	Annual	NA	120	3000	8000	8000	System for Programme Monitoring
Percent of providers who correctly identify ways of preventing the sexual transmission of HIV and who report major misconceptions about HIV transmission	Number of providers with comprehensive knowledge	Number of providers surveyed	Annual	NA	NA	80%	70%	80%	Pretest survey
Among men who have sex with men and who had more than one partner in the past six months, the percent who used a condom at last sex	Number who report using a condom at last sex	Number of men who had sex with more than one other man in the past 6 months	Annual	NA	NA	70%	80%	80%	Behavioral surveillance
HIV prevalence among sex workers	Number of sex workers reporting consistent condom use in past month	Number of sex workers surveyed	Every 3 years	NA	NA (70% in numbers)	80%	90%	80%	Behavioral surveillance
Prevention among general population									
Percentage of women and men aged 15-49 who had sex with more than one partner in the last 12 months of those who are sexually active	Number of women and men aged 15-49 who had sex multiple partners in the last 12 months	Number of women and men 15-49 who had sex in the last 12 months	Every 3 years	W 3% M 22% (2005)	W 3.5% M 18.1% (2008)	W 1% M 12% (2010)	W 1% M 10% (2011)	W 1% M 8% (2012)	DemHS
Number of safe male circumcisions that have been performed in the last 12 months in medical facilities	NA	NA	Annual	NA	To be determined after situation assessment				Programme reports
HIV prevalence among women and men aged 15-24	Number of HIV positive women and men aged 15-24 surveyed in survey	Number of men and women aged 15-24 surveyed in survey	Annual	NA	NA	12%	10%	8%	DemHS
Percent of young women and men 15-19 who had sex before the age of 15	Number of HIV positive women and men aged 15-19 surveyed in survey	Number of men and women who had sex before age 15	Every 3 years	W 1.8% M 21.2% (2005)	W 1.2% M 18.2% (2008)	W 0% M 11% (2010)	W 0% M 12% (2011)	W 0% M 10% (2012)	DemHS

Indicator	Measure	Developable	Frequency	2008-10	2011-13	2014-16	2017-19	2020-22	2023-25	2026-28	2029-31	Notes
Governance and Management												
Percent of national coordination bodies (NAC/NAMACOC/NAMACOC) scheduled meetings held per year with a representative quorum	Number of meetings that met quorum	Number of NAC/NAMACOC/NAMACOC meetings held	Annual	N/A	100%	100%	100%	100%	100%	100%	100%	March/June
Percent of regional coordination bodies (RACOC/CACOC) implementing a HIV and AIDS plan and budget	Number of coordination bodies representing with plan and budget	Number of coordination bodies (147 total)	Annual	N/A	R 80% C 80%	R 100% C 80%	R 100% C 80%	R 100% C 80%	R 100% C 80%	R 100% C 80%	R 100% C 80%	System for Programme Monitoring
Percent of clinics with an HIV and AIDS plan and budget (programming)	Number of clinics representing with plan and budget	Number of clinics (2)	Annual	N/A	100%	100%	100%	100%	100%	100%	100%	System for Programme Monitoring
Percent of CDFV funds spent on HIV and of total HIV expenditures	Government expenditures on HIV/AIDS	Total HIV expenditures in year	Annual	N/A	10%	10%	10%	10%	10%	10%	10%	Ministry of Finance
Percent of government funding committed to health	Government expenditures on health	Total government expenditures in year	Annual	10%	10%	10%	10%	10%	10%	10%	10%	Ministry of Finance
Percent of women and men (15-49) expressing acceptable attitudes in 4 questions about HIV	Number of women and men aged 15-49 expressing acceptable attitudes	Number of women and men aged 15-49 surveyed	Every 3 years	N/A	R 100% M 80%	R 100% M 80%	R 100% M 80%	R 100% M 80%	R 100% M 80%	R 100% M 80%	R 100% M 80%	Demographic
Human Resources												
Ratio of the staff establishment versus the number of patients assigned	Number of staff in MCH/MSL/General practice	Number of MCH/MSL/General practice patients assigned	Annual	N/A	M 100% R 80% Ph 80%	M 100% R 80% Ph 80%	M 100% R 80% Ph 80%	M 100% R 80% Ph 80%	M 100% R 80% Ph 80%	M 100% R 80% Ph 80%	M 100% R 80% Ph 80%	March/June
78												
78 treatment success rate	Number of new clinical practice TB patients cured and treated successfully	Number of patients notified the previous year by category	Annual	80%	80%	80%	80%	80%	80%	80%	80%	Demographic
Percentage of TB patients with known HIV status	78 patients with known HIV status	78 patients with the prior year	Annual	N/A	50%	50%	50%	50%	50%	50%	50%	HIV/AIDS

ANNEX 3: LIST OF PARTICIPANTS

Name	Representing	Groups
A. Tjaronda	MoHSS Directorate of Special Programmes	RH
Angela Von Wietersheim	UNICEF	GP
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Ainah Schikwambi	MoHSS PMU	HBC
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Anna Jonas	MoHSS Directorate of Special Programmes	HBC
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Nicolene Ochs	Expert patient trainer	ARV, PMTCT
Nolan van der Roos	Ministry of Education	OVC
Olufemi Okeo	WHO	RH, ARV
Pamela Onyango	MoHSS PMU	Models
Pandu Hailonga	UNFPA	RH, GP
Pangani Dhliwayo	MoHSS Directorate of Special Programmes	TB
Peter Gichagni	USAID	PEP, PMTCT
Petrina Johannes	Expert patient trainer	ARV, VCT
R. Heyman	NASOMA	RH
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Uchenna Nwokenna	MoHSS PMU	HBC
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Vera Bronkhorst	Office of the Prime Minister	WPP
Wilhelmina Kafitha	MoHSS Directorate of Special Programmes	HBC

Note: Some groups did not keep attendance lists so group memberships might be incorrect.

PMTCT=Prevention of mother to child transmission; TB=Tuberculosis; VCT=Counseling and testing services; RH=condoms, sexually transmitted infections and reproductive health; ARV=Antiretroviral treatment; PEP=safe medical injection, blood transfusion and post exposure prophylaxis; WPP=Workplace programmes; GOV=Governance and mainstreaming; HBC=Home based and palliative care; VG=Prevention among vulnerable groups; OVC=Orphans and vulnerable children programmes; GP=Prevention among general population.

Introduction=the individual attended for the introduction and HIV estimates and projections models on day 1.

Wrap up=the individual attended for the wrap up on day 4.

ANNEX 4: DETAILED PROGRAMME

Monday, 11 February, 2008

Objective: To familiarize participants with model estimates and projections

8:00-8:30	Tea and Registration	
8:30-8:50	Opening Address and Workshop Objectives	Dr. Goraseb, DSP
9:30-10:00	Background and Methodology of the workshop	Sandra Owoses, DSP
8:50-9:30	Target setting: Experiences from other countries	Salvator Niyonzima
10:00-10:30	Tea Break	
10:30-11:00	Why do we need models for HIV estimates and projections	Mary Mahy, UNAIDS
11:00-13:00	Assumptions for the Namibia model	Mark Damesyn, CDC
13:00-14:00	Lunch	
14:00-16:00	Results from the Namibian Model	Efraim Dumeni, DSP
16:00-16:30	Tea Break	
16:30-17:00	Final conclusions and adoption of results	Sandra Owoses, DSP

Tuesday, 12 February, 2008

Objective: To review programme indicators and baselines and decide on targets

8:30-9:00	Tea and Registration	
9:00-9:15	Opening and workshop objectives	Esther Andreas, Catholic AIDS Action
9:15-9:30	Methodology	Jeanette dePutter, EU
9:30-11:30	Breakout session # 1 <ul style="list-style-type: none"> • Group 1: PMTCT • Group 2: Tuberculosis • Group 3: C&T • Group 4: STIs/Condoms/ Reproductive Health 	Facilitators: F. Soroses R. Indongo I. Pieterse, D. Kangudie S. Tobias, F. Oke
11:30-12:00	Tea break	
12:00-13:00	Presentation of targets in plenary	Chair: J. Hanson, CDC
13:00-14:00	Lunch	
14:00-16:00	Breakout session # 2 <ul style="list-style-type: none"> • Group 5: ART • Group 6: Safe Medical Injection, Blood transfusion, PEP • Group 7: Human resources 	Facilitators: N. Hamunime, F. Simeon, Cancelled
16:00-17:00	Presentation of targets in plenary	

Wednesday, 13 February, 2008

Objective: To review programme indicators and baselines and decide on targets

8:30-9:00	Tea and Registration	
9:00-9:15	Opening and workshop objectives	Joyce Nakuta, MGECW
9:15-9:30	Methodology	Jeanette dePutter
9:30-11:30	Breakout session # 3 Group 8: Workplace programmes Group 9: Governance, regional support, and mainstreaming Group 10: Home based care and palliative care Group 11: BCC – vulnerable groups (incl. PLWHAs)	Facilitators: A. Kessler J. Karirao W. Kafitha, Ian Swartz
11:30-12:00	Tea break	
12:00-13:00	Presentation of targets in plenary	Chair: Kathrin Lauckner, GTZ
13:00-14:00	Lunch	
14:00-16:00	Breakout session # 4 • Group 12: Orphans and vulnerable children • Group 13: Food security & nutrition • Group 14: Behaviour change - general public and youth	Facilitators: B. Nshimimana, D. Yates Cancelled B. Schwarz
16:00-17:00	Presentation of targets in plenary	Chair: Nick DeLuca, CDC

Thursday, 14 February, 2008

Objective: To agree on a set of national targets (sub set of programme targets)

8:30-9:00	Tea and Registration	
9:00-9:15	Objectives of the day on national indicators and targets and methodology	National Planning Commission
9:15-9:30	Methodology	Sandra Owoses, DSP
9:30-11:00	Breakout sessions • Group A: Enabling Environment/ management • Group B: Prevention • Group C: Access to Treatment, Care and Support • Group D: Impact mitigation services	Facilitators: Kathrin Lauckner Rushnan Murtaza
11:00-11:30	Tea break	
11:30-13:00	Feedback in plenary	Chair: Salvator Niyonzima, UNAIDS
13:00-14:00	Lunch	
15:30-16:00	Tea break	
16:00-17:00	Main conclusions and closing	Ms. Ella Shihepo (DSP)

