Monitoring and Evaluation

of the

Civil Society contribution to tackling HIV/AIDS in Namibia

2007

Current levels of activity among NGOs, CBOs and Faith Based Organisations in relation to tackling HIV/AIDS in Namibia

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Abbreviations and Acronyms

AIDS	Acquired Immuno-deficiency Syndrome
ARV	Anti-retroviral drugs
BCI	Behaviour Change Intervention
CACOC	Constituency AIDS Coordinating Committee
CAFO	Churches Alliance for Orphans
CAP	Community Action Plan
CBO	Community-based Organisation
CDC	Constituency Development Committee
CSO	Civil Society Organisations
DAC	District AIDS Committee
FBO	Faith-based Organisation
FHI	Family Health International
HIV	Human Immuno-deficiency Virus
IEC	Information, Education and Communication
LA	Local Authority
M&E	Monitoring and Evaluation
MoHSS	Ministry of Health and Social Services
MRLGHRD	Ministry of Regional and Local Government, Housing and Rural Development
MTP II	The National Strategic Plan on HIV/AIDS – Second Medium Term Plan
MTP III	The National Strategic Plan on HIV/AIDS - Third Medium Term Plan
NACOP	National AIDS Coordination Programme
NACP	National AIDS Control Programme
NANASO	Namibia Network of AIDS Service Organisations
NANGOF	Namibia NGO Forum
NGO	Non-governmental Organisation
OVC	Orphans and Vulnerable Children
PLWHA	People living with HIV/AIDS
RAC	Regional AIDS Co-ordinator
RACOC	Regional AIDS Coordinating Committee
STI	Sexually transmitted infection
TB	Tuberculosis
VCT	Voluntary Counselling And Testing

Foreword

The Namibia Network of AIDS Service Organisations (NANASO) is making an important contribution to the National HIV/AIDS response. The network and its members acknowledge the fact that monitoring and evaluation is imperative for any network and civil society organisation that implements activities.

NANASO as a network is mandated through the National HIV/AIDS Strategic Plan (MTP III) to conduct an annual monitoring exercise to inform the national HIV/AIDS response on the contribution and performance of civil society . Therefore, I am pleased that the annual monitoring reports are printed and disseminated, and the reports serves as an important contribution to the overall monitoring and evaluation of the national response .

Through comprehensive and systematic monitoring processes, a network is able to detect trends among and quantify the outcome of the collective effort of the civil society . As a result NANASO is able to plan more effective and improve the organisations management and implementation.

It is also highly relevant to see the trends among civil society organisations contribution to the overall response. Civil society plays a crucial in service provision to Orphan and Vulnerable Children, Home Based Care and Palliative Care, and Information, Education and Communication as well as in social mobilisation and behaviour change communication. Especially regarding the letter Namibia needs to strengthen the activities and civil society organisations are close to the communities and vulnerable groups that we need to target.

Monitoring and evaluation does assist in strengthening the effectiveness and efficiency of interventions and therefore it is a highly relevant part of our planning and implementation . I greatly appreciate NANASO's efforts in this regard and sincerely encourage civil society to continue the quality service delivery at the community level .

Mr K. Kahuure

Permanent Secretary

Ministry of Health Social Services

Monitoring and evaluation of the Civil Society contribution to tackling HIV/AIDS in Namibia

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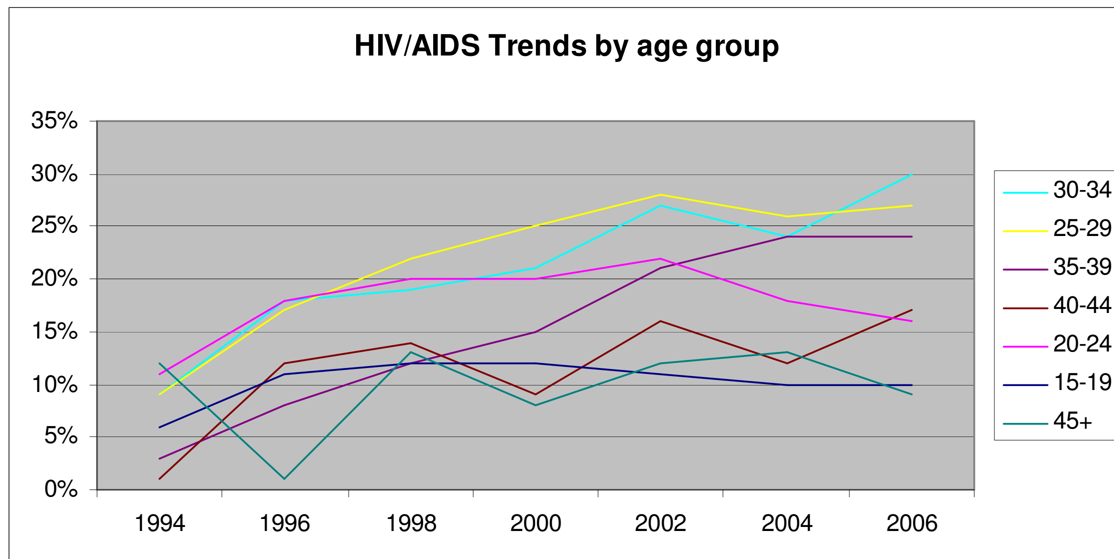
1 Introduction

1.1 Background

- Namibia's relatively small population of 2 million people has one of the highest HIV prevalence rates in the world
- Approximately 20% of the sexually active adult population lives with the virus
- By 2006, approximately 220,000 people aged between 15 and 49 were infected
- In 2000, AIDS was Namibia's number one cause of death and accounted for 28% of deaths in all age groups
- The Ministry of Gender and Child Welfare now has 140,000 children under the age of 15 registered as orphans, most of these have lost one or both parents due to AIDS
- At independence in 1990, life expectancy stood at 60 years. In only 16 years it has dropped to around 40 years
- The spread of HIV/AIDS is exacerbated by high unemployment rates, poverty and violence against women and children
- While the incidence of infections appears to be falling among younger people, infections are rising among people aged between 25 and 40

Table/Graph 1 HIV prevalence among women in 2006 ranked by degree of infection rates



In short, HIV/AIDS is one of the top issues affecting Namibia in relation to its social economic development. No family is unaffected.

1.2 MTP III as a planning basis for Namibia's activities in tackling HIV/AIDS[1]

The National AIDS Control Programme (NACP) was launched in 1990 soon after Independence. The Short Term Plan followed closely behind. This in turn was followed by the First Medium Term Plan launched in 1992 to cover the period 1992-1998. The NACP was to co-ordinate and manage HIV/AIDS patient care and preventative activities. The NACP

[1] This section is drawn from Chapter 1 of "The National Strategic Plan on HIV/AIDS - Medium Term Plan III for HIV/AIDS (MTP III) 2004 - 2009 published by the Republic of Namibia

was based within the Ministry of Health and Social Services, but it supported activities implemented by other ministries and NGOs.

The review of the First Medium Term Plan conducted in 1997 found that extensive awareness campaigns had been undertaken to good effect, that political commitment had been clearly articulated and that management structures were in place. The recommendations focused on the further development of programme management, initiating more targeted IEC campaigns and strengthening multi-sectoral involvement.

The Second Medium Term Plan (MTP II) was launched in 1999 for the period 1999-2004. MTP II established the National AIDS **Co-ordination** Programme (NACOP), replacing the National AIDS **Control** Programme. MTP II set out six broad objectives for the NACOP. These were to i) reduce the number of HIV infections in both adults and children through the strengthening of support to preventive efforts; ii) ensure that all Namibians living with HIV and their families have access to services that are affordable, of high quality and responsive to their needs; iii) empower individuals, families and community members with knowledge and skills related to prevention, home-based care and self-protection against HIV/AIDS infection; iv) ensure that all Namibians living with HIV and their families are not subjected to any form of discrimination; v) establish national and regional programme management structures for the co-ordination and monitoring of the implementation of the national response; and vi) ensure continuous support by both national and international communities in order to address the socio-economic impact of HIV/AIDS.

MTP II provided a comprehensive framework for the national multi-sectoral and sub-regional response to HIV/AIDS. It aimed to:

- Involve all sectors to expand the national response to HIV and AIDS
- Link prevention to care and support for persons or families affected by HIV and AIDS to reduce stigmatisation
- Strengthen the capacities of regional councils and local authorities to co-ordinate, manage and monitor HIV and AIDS activities
- Establish partnerships with private sector and civil society organisations to implement programmes.

MTP II was reviewed in February 2003. The recommendations from the Review guided the formulation of the third Medium Term Plan (MTP III). This plan builds on the strengths of the previous programme and addresses the areas identified for renewed attention and commitment, as well as for human resource capacity building, improved financing and enhanced coordination and cooperation. It identifies clear sectoral obligations and requires these sectors to establish processes whereby progress is monitored and evaluated during the progress of the plan.

For the NGO sector, MTP III sets out a comprehensive set of actions, with the coordinating bodies being NANASO, the Namibia NGO Forum (NANGOF) and Lironga Eparu. Target Groups are seen as HIV/AIDS infected and affected people throughout Namibia, especially vulnerable communities, Community Based Organisations (CBOs), support groups and NGO staff.

MTP III was reviewed in 2007. However, the results of that review had not been made public by the end of January 2008.

NGO Sector Objectives are described in MTP III as:

1. Develop the capacity of all members, especially smaller, rural organisations through access to technical support and small grants
2. Support local responses to HIV/AIDS by training in HIV/AIDS project management and providing up-to-date information

3. Consistent and frequent participation in all relevant coordinating mechanisms to ensure that NGO/CBO needs and contributions are understood at national and regional level
4. Improve capacity of sector for monitoring and evaluation

A table in MTP III sets out the detailed commitments for NGOs:

NGO Sector's Commitments	**MTP III Ref**
Enabling Environment	
Provide information, materials and training in local languages to traditional healers, religious, political and traditional leaders and other community leaders concerning the necessary change in attitudes and in behaviour and reduction of discrimination of those living with and affected by HIV/AIDS, STIs and TB	1.1.1
To organise and participate in AIDS awareness campaigns to influence the general public and opinion leaders	1.1.1
Deal with HIV/AIDS as a human rights issue and provide basic client services in terms of legal advice, litigation, policy formation and education and advocacy.	1.2.2 1.3.3
Prevention	
To develop or use existing behaviour change communication material and interventions for targeted groups based on research within communities, and ensure consistent expression of basic ABCD messages in the sector	2.2 and 2.3
Targeted behaviour change communication and interventions (BCI) for children and young people in primary and secondary educations/institutions including comprehensive life skills intervention efforts with a sexual and reproductive health component and counselling services	2.3.1
Expand social mobilization and awareness interventions that target the general population for the prevention of HIV and STI infections	2.4.1
Develop and implement workplace programmes and policies	2.4.2
Scale up the country wide supply and distribution of male and female condoms for the general through public, private and social marketing mechanisms	2.4.3
Provide Adolescent Friendly Reproductive Health information and services	2.4.3
Expand Voluntary Counselling and Testing provision and support the training of community counsellors	2.4.5
Treatment, Care and Support	
Facilitate and train community home-based care groups	3.2.4
Provide the general public with IEC on treatment and care for PLWHA.	3.1.2
Mitigating the Impact	
Mobilise and support through training and resource mobilisation CBOs to actively and constructively participate in HIV/AIDS programmes	4.1.1
Capacity building for the Network of People Living With HIV/AIDS as well as promoting and providing support groups for people living with HIV/AIDS	4.1.2
Expand and improve the care and support available for orphans and vulnerable children	4.2.1
Develop a national community educational campaign to ensure non-discriminatory access to the available social assistance grants, allowances and other services for OVC and people living with and affected by HIV/AIDS.	4.2.1
Programme Management and Coordination	
Ensure NGOs/CBOs are represented at all levels in programme coordination and management structures	5.2.1
Strengthen and coordinate national and regional resource mobilization and flow mechanisms to support the HIV/AIDS STI and TB programmes at all levels	5.2.2
To ensure horizontal learning through sharing best practices with members through newsletters, workshops, and other effective communication systems	5.2.3
To develop, annually update and maintain the Directory of NGOs/CBOs	5.2.4
Develop monitoring and evaluation systems and procedures	5.3.1

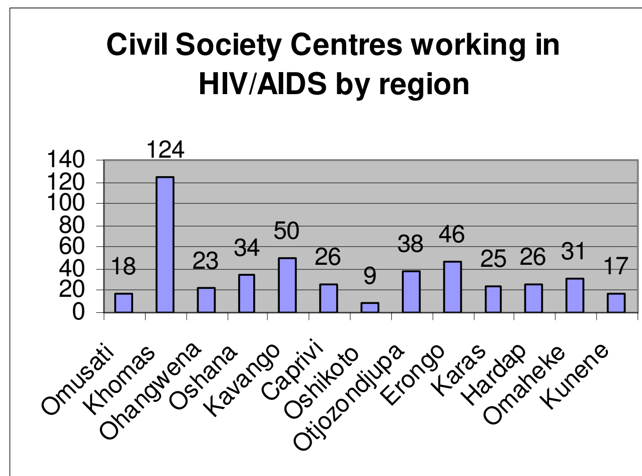
1.3 Civil Society engagement in HIV/AIDS

Although MTP III identifies joint leadership in relation to NGOs (NANASO, NANGOF and Lironga Eparu), in practice, Lironga Eparu has focussed on its network of local Lironga Eparu branches and NANGOF has been focussed on a recovery plan to rebuild itself as the overall umbrella for civil society. This has left NANASO to take the lead in coordinating civil society efforts in the field of HIV/AIDS, which it has done through a programme of Communication, Facilitation, Co-ordination and Monitoring and Advocacy.

NANASO works on an open network basis, seeking to be in contact with any NGO, CBO or Faith Based Organisation (FBO) that is active in the field of HIV/AIDS. An indication of the extent of its contact range is that it currently has on its database (with a named contact) 167 NGOs, 143 CBOs and 44 FBOs – a total of 354 organisations. Of these, 86 of the NGOs, 123 of the CBOs and 26 of the FBOs are based outside Windhoek. In other words, the effort is spread right across the country and NANASO is succeeding in achieving a full national coverage as a network organisation, despite the fact that it has no regional offices.

The 354 organisations have a combined total of 467 centres. The distribution of these centres by region is shown in the graph below. As will be explained in more detail later in the report, the regions are listed from left to right according to the scale of the HIV/AIDS problem in a region. Thus it is disappointing to note that the number of centres in Omusati and Ohangwena are lower than in other regions, given the scale of the need in those regions.

Table/Graph 2 Civil society centres working in HIV/AIDS by region



NANASO's database shows that civil society organisations are remarkably diverse, ranging from the Development Aid from People to People and its Total Control of the Epidemic Programme, which records 558 full time staff and 4,275 volunteers, or the Namibia Red Cross Society, which records 57 staff and 4,000 volunteers, to entirely voluntary organisations operating in a single constituency.

Data is available on 284 of the 360 organisations on the database as to which regions they work in. 221 (63%) record that they work just in their home region, with a further 13 (4%) working in just 2 regions. In other words, most agencies are very local, with two thirds of the organisations working in just one or two regions.

In total there is information on staff and volunteers for 310 organisations on the database. These employ nearly 1,700 full time staff and over 400 part time staff who, fully or in part, are focussed towards tackling HIV/AIDS in some way or other.

Table/Graph 3 Analysis of employment and volunteer data

Organisations	Number of organisations	% of orgs	Number of full-time staff	Number of part-time staff	Number of volunteers	Average number of volunteers
No full-time staff recorded	138	45%	0	92	2,833	21
1-9 staff	139	45%	484	272	7,002	50
10-19 staff	23	7%	278	43	1,663	72
20+ staff	10	3%	918	20	10,075	1,008
Totals	310		1,680	427	21,573	70

More strikingly these organisations record over 20,000 volunteers. It is an effort that needs to be both nurtured and recognised for what it is - a massive, un-costed contribution by an awake and concerned population towards tackling the epidemic.

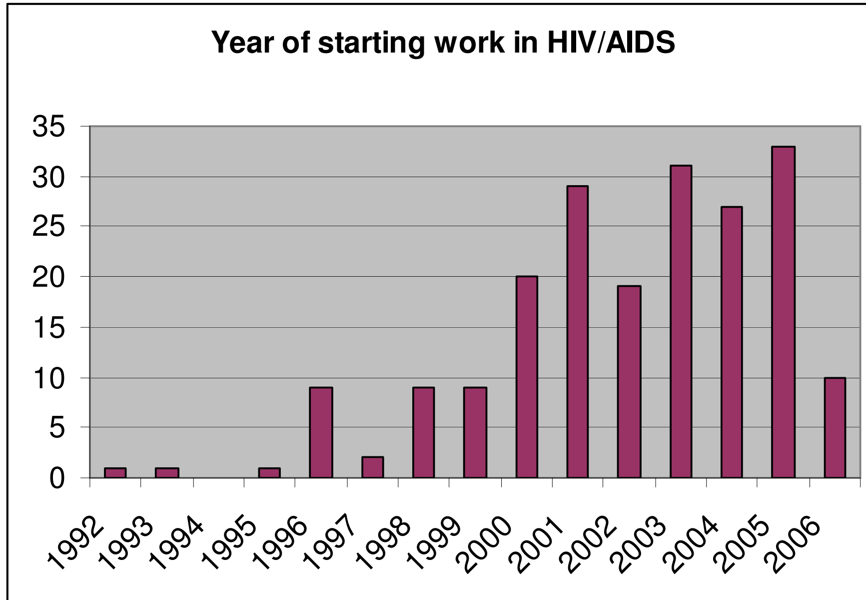
The numbers engaged in this national effort have remained quite consistent over the 3 years in which NANASO has been formally monitoring this data, although the numbers of organisations for which data is held is rising. It is not clear whether this rise reflects a real rise in the number of organisations involved in the national AIDS effort or a more comprehensive coverage in NANASO's data collection.

Table/Graph 4 Analysis of total employment and volunteer data 2005-7

Organisations	Number of organisations	Number of full-time staff	Number of part-time staff	Number of volunteers	Average number of volunteers
2005	243	844	283	15,252	63
2006	280	1,720	367	20,825	74
2007	310	1,680	427	21,573	70

Noticeable is how recently civil society organisations (CSO) have started to respond to the the epidemic, given that the first case of AIDS in Namibia was formally recorded in 1986. Awareness at a national, policy level is long standing. For example, NANASO was formed as the umbrella organisation for Aids Service Organisations in 1991 and major awareness programmes were being mounted in the early 1990s. However, it was only in 1998 that one of the biggest Namibian civil society AIDS service organisations, Catholic Aids Action, was founded. The graph below of the 201 centres which have recorded both their year of founding and the year in which they started work in HIV/AIDS on the NANASO database shows a substantial engagement in the last 5 years, with 60% of organisations starting work on HIV/AIDS in the last 5 years and 85% having started work since 2000. It is suggested that the graph reflects a real change of awareness in the country since 2000; people finally recognise that AIDS is real, it affects them and they can do something about it.

Table/Graph 5 Year in which sample of CSOs started work in HIV/AIDS



Of the 201 centres, 154 (77%) were founded in the year in which they commenced work in HIV/AIDS, suggesting that they were formed for the purpose of working in the specific field.

1.4 Methodology of the M&E study

While MTP III is very clear in setting national goals, the scale of the number of organisations means that keeping track of what is going on within civil society is a challenge. Some of the larger organisations are able to offer good statistical statements of what they are doing and where. But it has already been noted that there is a considerable effort from small community based organisations. Simply looking at the national agencies gives a limited picture of the total effort.

This report is the third year in which NANASO has sought to establish what is happening throughout Namibian CSOs in relation to HIV/AIDS, following the framework established by MTP III.

As previously noted, NANASO works on an open basis and includes in its network support all NGOs, CBOs and FBOs that work in the field of HIV/AIDS. It combines the data gathering for this M&E study with a regular visiting programme covering all regions at least once each year. The visiting the programme is multi-faceted, aiming to:

- Provide a bridge between the individual, community based organisations and the national programme
- Show individual centres how their efforts fit with the national effort
- Establish the detail of what an individual centre has been doing in the previous 3 months, to reflect this in this national M&E study
- Encourage and mentor the individual centres

Thus less attention is given to formal sampling methods in the study, with more attention to trying to establish contact with and act as a bridge for individual organisations on the ground. Over the 3 years in which this M&E exercise has taken place, some 300 centres have provided data for the study through the visiting programme. Many more have been visited but have not been able offer firm data.

Table/Graph 6 Distribution of M&E visits 2005 , 2006 and 2007

	Total centres	Visited in 2005	Visited in 2006	Visited in 2007	2007 visits as % of all centres
Caprivi	26	11	9	22	85%
Erongo	46	12	16	20	43%
Hardap	26	6	6	9	35%
Karas	25	2	2	10	40%
Kavango	50	7	18	24	48%
Khomas	124	13	22	40	32%
Kunene	17	5	8	7	41%
Ohangwena	23	7	7	15	65%
Omaheke	31	13	6	12	39%
Omusati	18	3	2	14	78%
Oshana	34	10	9	18	53%
Oshikoto	9	4	3	7	78%
Otjozondjupa	38	12	5	14	37%
	467	**105**	**113**	**212**	**45%**

The programme of visiting in 2007 was extensive across all regions. When compared with the NANASO database, at least one third of all organisations in a region were visited, rising to most of the known organisations in Caprivi being visited (85%).

Data is almost entirely gathered by face to face to interview. A small number of centres choose to provide their data through a written questionnaire.

32 of the centres gave data on their activities in each of the years 2005, 2006 and 2007 and this data is compared in Chapter 4.

The data by regions was presented in a standard order in the 2 previous M&E Reports, with the order of the regions based on translating the 2004 Sero-Sentinel Survey data into regionally comparative data that showed the numbers of people who are likely to be HIV+. Thus, while Caprivi has the highest prevalence rate, the population numbers in Caprivi are dwarfed by the population numbers in other regions. Using the basis of population likely to be infected gives a different rank order to the rank order of regions defined by prevalence rate.

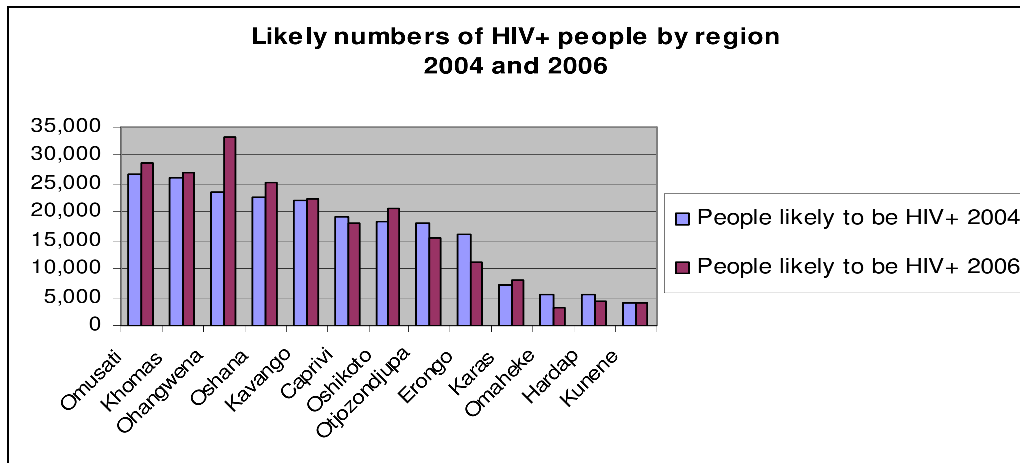
Since the first 2 reports, the 2006 Sero-Sentinel Survey data has become available. This data, combined with different rates of population growth (arising from migration and other factors), suggests that the numbers likely to be HIV+ in a region will have changed, as shown in the Table and Graph below:

Table/Graph 7 Numbers of likely HIV Prevalence by region: 2004 and 2006[2]

	Prevalence 2004	People likely to be HIV+ 2004	Rank		Prevalence 2006	People likely to be HIV+ 2006
Omusati	20.8%	26,676	1	Ohangwena	24.5%	33,286
Khomas	16.7%	26,030	2	Omusati	22.1%	28,665
Ohangwena	18.2%	23,640	3	Khomas	16.7%	26,949
Oshana	24.9%	22,736	4	Oshana	27.1%	25,281
Kavango	18.2%	22,066	5	Kavango	17.3%	22,282
Caprivi	42.6%	19,280	6	Oshikoto	21.7%	20,566
Oshikoto	19.7%	18,373	7	Caprivi	39.4%	18,121
Otjozondjupa	22.8%	18,187	8	Otjozondjupa	18.8%	15,459
Erongo	27.0%	16,009	9	Erongo	18.7%	11,286
Karas	18.7%	7,255	10	Karas	20.9%	8,122
Hardap	14.9%	5,419	11	Hardap	12.1%	4,372
Omaheke	13.8%	5,499	12	Kunene	10.3%	4,101
Kunene	9.5%	3,876	13	Omaheke	7.9%	3,214
Totals		**167,796**			**100%**	**32,257**

The table can be shown as a graph:

Table/Graph 8 Chart of likely HIV Prevalence by region: 2004 and 2006



Thus it will be seen that Ohangwena, ranked as the third region in terms of likely number of HIV+ people in 2004, moves to rank 1, with Khomas falling to rank 3 (compared to rank 2 in 2004). Regions where the numbers appear to be falling include the Caprivi, Otjozondjupa, Erongo, Omaheke, Hardap and Kunene.

Although the rank order of regions by population calculated as infected has changed between 2004 and 2006, the 2004 rank order will be used throughout this 2007 report in

[2] The table is based on a number of assumptions. It takes the prevalence rates found among pregnant mothers tested for HIV by testing centre. It allocates those centres by the region in which they are based and in this way calculates the prevalence by region, as opposed to testing centre. By combining this prevalence data with the regional census data (adjusted for population growth since the census and for the proportion of the population that is sexually active), it is possible to approximate the number of people who are HIV+ in a region. Finally, the number of these who are likely to have developed AIDS has been estimated on the basis that 15% of the HIV+ population is likely to have developed AIDS.

regional tables, to give some continuity in view as to how actual activities match perceived need.

1.5 Issues relating to the data gathering process

Organisations were asked what they were doing in any relevant field defined by MTP III, how many events they had undertaken in the last 3 months and how many people had been affected by the events. The results are presented in Chapter 3. However, some comments on the process itself will be useful to set the results in context:

- When the surveys commenced in 2005, many organisations were still not fully familiar with MTP III; thus the research had a secondary result of informing organisations of the background to the national effort directed towards tackling HIV and AIDS. Now that the third survey has been completed, the awareness of MTP III has risen. This will have led to some redefinition of activities during the 3 surveys with an unpredictable impact on the data collected over the 3 surveys.
- Some events can impact across several aspects of MTP III. For example, a drama presentation might cover 3 or 4 separate headings within MTP III. Groups often commented that they tried to make scarce resources go further by tackling several issues at, say, the same community meeting. Where this happened, the event was recorded under each heading. Thus there is double counting in relation to the number of events and the people recorded as having benefited from the events.
- An event could be any discrete activity - examples would be a visit, a meeting, a clinic, a workshop. However, the same activities were sometimes recorded differently by different groups. Thus the distribution of condoms might be described by the number of outlets in an area, or the number of people receiving condoms, or the number of condoms distributed.
- This became particularly problematic in relation to the data Expand condom distribution. In the case of some organisations, data was received in 2006 and 2007 in respect of the total number of condoms distributed across the country. These totals were divided by 30 to better reflect the likely number of people likely to be benefiting from this particularly programme
- In general, organisations found it difficult to indicate numbers and particularly difficult to indicate numbers by constituency (although constituency specific information is improving). Even by the third study in 2007, there were too many organisations guessing what activities they had carried out in the reporting period or how many had benefited.
- 2007 is the first year in which respondents specifically recorded their radio and TV coverage. The numbers covered by these two media are significant. In one case, the organisation felt that it was reaching 500,000 people through TV programmes; in the other case, another organisation felt that it was reaching almost half the population of the region through its radio programmes. These numbers benefiting are of a different scale to other activities and so the number of people recorded as having benefited have been excluded from the charts.

2 Progress on the NGO Sector Objectives in 2007

2.1 The NGO Sector Objectives

NGO Sector Objectives are described in MTP III as:

1. Develop the capacity of all members, especially smaller, rural organisations through access to technical support and small grants
2. Support local responses to HIV/AIDS by training in HIV/AIDS project management and providing up-to-date information
3. Consistent and frequent participation in all relevant coordinating mechanisms to ensure that NGO/CBO needs and contributions are understood at national and regional level
4. Improve capacity of sector for monitoring and evaluation

This Chapter considers progress in 2007 towards the Sector Objectives.

2.1.1 Develop the capacity of all members through access to technical support and small grants

The methodology of this M&E study is to combine the process of monitoring what NGOs are doing in tackling HIV/AIDS with mentoring through face to face contact at the individual centres. This tends to be more important for the smaller centres which do not have other, easy access to the national picture. The M&E teams report that some centres had specifically improved their M&E systems as a result of the visits in 2005; and others showed considerable appreciation at seeing how their efforts did, in fact, fit into the national MTP III programme.

Other technical support to members is available through the MTP III regional structures and through peer support. A 2006 workshop held by the Ministry of Health and Social Services (MoHSS) and the Ministry of Regional and Local Government, Housing and Rural Development (MRLGHRD) considered the issue of local responses to HIV/AIDS. In the workshop, it became clear that there are some good local responses in practice but that the local response mechanisms need to be strengthened. Proposals arising from the results of this workshop have been made and it is important that this is a process that is further jointly driven between the relevant Ministries and the civil society support structures[3].

In relation to access to small grants, NANASO was engaged in 2006 in Southern African regional research into the flow of funds to HIV/AIDS activities, particularly to smaller agencies. The research report was published in 2007[4], and the findings show that the need for more funds to go to local initiatives is great and the mechanisms for this need to be strengthened.

The report found that, at a global level, the flow of funds to civil society is good, with over N$300m being earmarked to civil society in Namibia between 2001 and 2006[5]. As can be seen from the graph below, by far the largest proportion of funds was directed towards

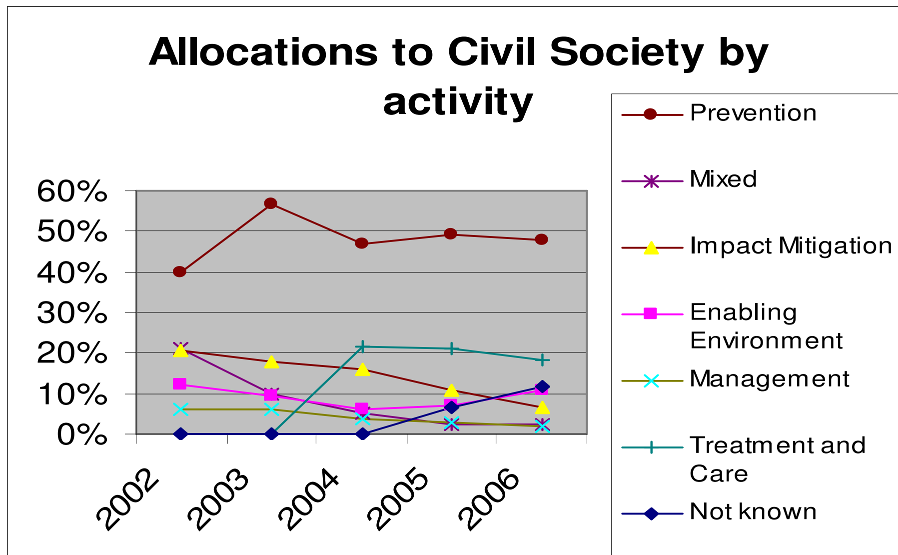
[3] Strengthening Local Responses to HIV/AIDS in Namibia, Ministry of Regional and Local Government,Housing and Rural Development and Ministry of Health and Social Services, 2007

[4] Pioneers, Partners, Providers; The Dynamics of Civil Society and AIDS Funding in Southern Africa, OSISA 2007

[5] Data was drawn from 21 funding agencies, which are understood to represent the largest funding sources for HIV/AIDS in Namibia. The primary source of the data was the UNAIDS Funding Matrix, which is a major database maintained by UNAIDS. In addition to this primary data, there was evidence of significant bilateral relationships between international funding sources and CSOs on the ground. It is estimated that these sources add some 15% - 20% to the funding flows.

prevention and this is reflected in the very high level of activity in this area found among CSOs during the research.

Table/Graph 9 Allocations of funds to Civil Society 2001-2006, by activity area



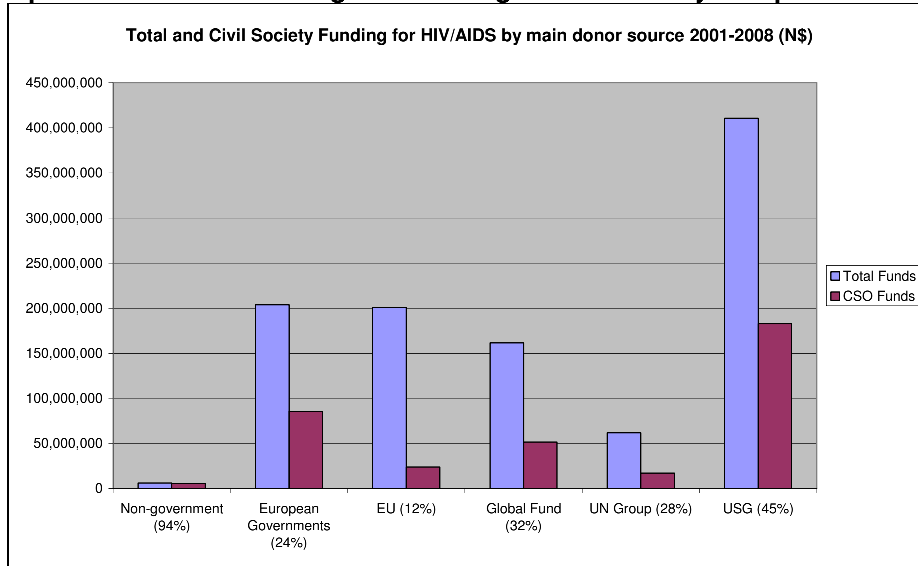
However, the research also found that funds were mainly directed to the larger civil society organisations. So, a total of 36 civil society organisations were recorded in the research as having received funding from the 21 funding agencies, with some CSOs receiving a relatively high number of grants.

Table/Graph 10 Grants recorded to individual civil society organisations 2001-6

Number of grants recorded to a CSO agency	Number receiving grants
1	10
2	6
3	5
4	2
5	4
7	3
9	1
11	1
12	1
13	1
15	1
21	1
Total agencies CSO receiving grants	36

There are clear differences of approach among funding agencies when it comes to allocating funds to civil society, with some agencies preferring to only fund government and some being very prepared to fund civil society. This is shown in the graph below, which maps funding allocations between 2001 and 2008 (although the data for 2007 and 2008 relates only to advance funding announced prior to May 2006).

Table/Graph 11 Total funding and funding to civil society compared



It is clear that there will be "mainstream" organisations that are able to absorb high levels of funding and undertake large-scale, national programmes. However, this profile of funding has to be matched against the profile of CSOs working in HIV/AIDS.

This M&E report records a much larger number of civil society agencies that are engaged in activities relating to HIV/AIDS than are actually receiving funds from the main donors. So the mechanisms that ensure that funds reach all civil society actors in HIV/AIDS are critical if a full coverage is to be achieved. Until the end of 2006, the main vehicles for reallocating funds from the larger donors to smaller agencies were Family Health International (FHI), the Church Alliance for Orphans (CAFO) and the Small Grants Fund.

By far the biggest of these sources was FHI, which the US Government used as its agent to disseminate funds to smaller organisations. Between 2001 and 2005, nearly N$80m was allocated through FHI, which had a clear commitment towards funding faith based organisations. The funding included grants to the Catholic Health Services, Lutheran Health Services and CAFO.

The Small Grants Fund has allocated nearly N$6m between 2002 and 2005 to nearly 100 organisations, using funds from the Swedish, Finnish and Netherlands Embassies. Its specific aim is to address the gap in funding to CBOs and to provide funding direct to community level. Grants are usually in the range of N$60,000-N$80,000 per project. People interviewed during the research emphasised the importance of this particular mechanism.

What is clear from the research is that, except where there is a specific mandate associated with a given funding stream, larger organisations do not sub-contract smaller organisations to carry out activities within specific local communities. Thus, given the potential offered by the large number of community based initiatives directed towards tackling HIV/AIDS, there is a strong need to strengthen the existing mechanisms to allow a greater flow of funds towards locally based activities.

NANASO, with NANGOF support, has started to follow up the findings of this research by developing a database of funders and by commissioning consultants to examine how the mechanisms for funding flows to smaller organisations can be developed.

2.1.2 Support local responses to HIV/AIDS through training

In 2007 NANASO continued to focus its training activities on institutional capacity building, with training particularly directed towards smaller organisations. This bias towards institutional capacity building was essentially the result of the bias of funding that it received,

since strategically NANASO believes in a two-pronged approach to skills and capacity development:

- ❖ Institutional capacity training on a national basis, with Windhoek as the training centre and participants enabled to attend through the provision of accommodation and transport costs
- ❖ Service skills developed through regional workshops, with the aim of engaging as many organisations and individuals as possible while enhancing local networking.

Regrettably, while funds were available for regional service skills workshops in 2005, these were not available in 2006 or 2007 through NANASO. As a result, skills development took place through training programmes provided by individual NGOs; no information is available as to the scale of this training during 2006.

In 2006, NANASO, !Nara and NANGOF joined together to improve the quality of capacity building training for NGOs. This will lead to a nationally accredited NGO Management qualification and a more structured approach to a national training framework. In 2007, this included NANASO coordinating training for 125 individuals (slightly down on the 150 people trained in 2006). It also led to the registration of 2 national unit standards of training relating specifically to HIV/AIDS and national consultation on a further 12 unit standards relating to general management skills. The foundations for a mentoring programme were formally set and more detailed planning for the implantation of the NGO Management Qualification commenced.

2.1.3 Representation of NGO/CBO needs at national and regional level

One role of NANASO as a Network organisation is to act as a bridge between the network members and:

- International civil organisations and institutions such as the International Council of AIDS Service Organisations (ICASO), Africa Council of AIDS Service Organisations (ACASO), Southern Africa Network of AIDS Service Organisations (SANASO) and Southern African for AIDS (SAfAIDS)
- UN agencies, UNAIDS, UNDP, UNFPA and UNICEF, and development partners such as, SIDA, USAID, Africa Groups of Sweden, DED and Inwent
- Namibian government institutions such as Ministry of Health and Social Services, Ministry of Women and Child Affairs, Ministry of Information, National AIDS Coordinating Committee (NACOP), the National AIDS Executive Committee (NAEC), National AIDS Country Coordinating Mechanism (NACCATUM) and the Regional AIDS Coordinating Committees (RACOCs)
- Local umbrella bodies and institutions such as the Namibian NGO Forum (NANGOF), Namibia Business Coalition on AIDS (NABCOA), Joint Consultative Council (JCC), Council of Churches in Namibia (CCN) and Lironga Eparu

NANASO sought to ensure that CSOs were fully represented at each of these levels.

2.1.4 Improve capacity of sector for monitoring and evaluation

NANASO has been actively developing M&E capacity since 2004. At an overall level, this report is the third year in which it has produced a picture of national activity among CSOs. In the process, it has begun to define a sample reference group, from which trends in activity over time can be properly measured.

NANASO has also been active in the effort towards a national M&E framework, with the National Coordinator chairing this programme. This has led to a series of baseline data being defined, from which the overall national effort can be monitored. This national programme was fully defined in 2007, with NANASO receiving assistance to employ a full-time M&E Officer for civil society activities.

At the individual organisation level, NANASO has sought to strengthen M&E activity in a number of ways:

- This annual M&E survey is its own encouragement to CSOs to understand and act upon the principles and practices of M&E
- In 2005, NANASO managed to secure funds for a number of regional M&E workshops; unfortunately it did not succeed in securing funds for further workshops in 2006
- The workshops that NANASO held in 2006 and 2007 included workshops in Project Cycle Management and General Management – both with a strong M&E bias

3 Progress on the NGO Sector's Commitments in 2007

3.1 Introduction

A total of 212 centres provided information on their activities in 2007, reporting on the three months period immediately prior to the survey interview. A complete list of the centres is an Appendix to this Report.

104 of the centres replying were NGOs, 55 were CBOs or HIV/AIDS Clubs and 45 Faith Based Organisations (FBOs), with a small number of other organisation types providing information (2 District AIDS Committees, 3 Trade Unions and 3 Parastatals) also recording data.

Table/Graph 12 Analysis of employment and volunteer data of centres with data

Organisations	Number of organisations	%	Number of staff	Number of part-time staff	Number of Volunteers
No full-time staff recorded	91	43%		34	2,408
1-9 staff	96	45%	362	212	4,685
10-19 staff	15	7%	175	34	1,281
20+ staff	10	5%	906	20	6,571
Totals	**212**		**1,443**	**300**	**14,945**

Although the sample was almost twice as big as those for 2005 and 2006, the number of centres with no full time staff remained about half of the total sample (43% in 2007; 51% in 2006). Another indicator of the size of the centres is whether a centre had an e-mail address. This remains more or less constant at just under 60% (59% in 2007, 56% in 2006 and 58% in 2005).

The profile of organisations and centres replying to the questionnaire was matched against the total NANASO database, according to the profile described in Chapter 1, to identify how representative the survey was, with the following picture:

Table/Graph 13 Survey centre staff and volunteers compared with overall NANASO database

	Number of organisations			Number of staff (full-time and part-time)			Number of volunteers		
	Database (organisations)	**Respondents**	**%**	**Database**	**Respondents**	**%**	**Database**	**Respondents**	**%**
0 full-time staff recorded	138	83	60%	92	34	37%	2,833	2,327	82%
1-9 staff	139	79	57%	756	508	67%	7,002	3,906	56%
10-19 staff	23	14	61%	321	192	60%	1,663	1,108	67%
20+ staff	10	10	100%	938	926	99%	10,075	6,571	65%
Totals	**310**	**186**	**60%**	**2107**	**1,660**	**79%**	**21,573**	**13,912**	**64%**

The data set of staff from the NANASO database is calculated by the number of organisations on the database. The 2007 respondents are according to centres providing data for the survey, adjusted to avoid double counting. Thus, by considering the number of staff and volunteers engaged in the surveyed centres against the total organisation staff and volunteer numbers, it is possible to suggest that the surveyed sample represents almost two thirds of the total activities undertaken by civil society.

Although the figures for staff and volunteers have now appeared to reach a broad plateau, monitoring teams report quite a lot of movement among staff and volunteers between organisations as a result of funding and changing activities. Emerging programmes such as the use of lay counsellors in hospitals have drawn volunteers from other activities because of the allowances paid.

3.2 Activities overall

Turning to the activities recorded overall, there have been some interesting changes in the focus of the centres over the three years. Those recording involvement in Creating an Enabling Environment have fallen from about three quarters to about one half – more or less the same level in 2007 as those recording involvement in Prevention new infections. The numbers recording involvement in Providing access to treatment, care and support remains static at around one third, but there has been a small rise in those involved in Mitigating the impact of HIV/AIDS to almost half of organisations seen. Finally, the numbers recording involvement in Integrated & co-ordinated programme management has risen significantly, as centres either improve their M&E activities, or recognise the merit of reporting these.

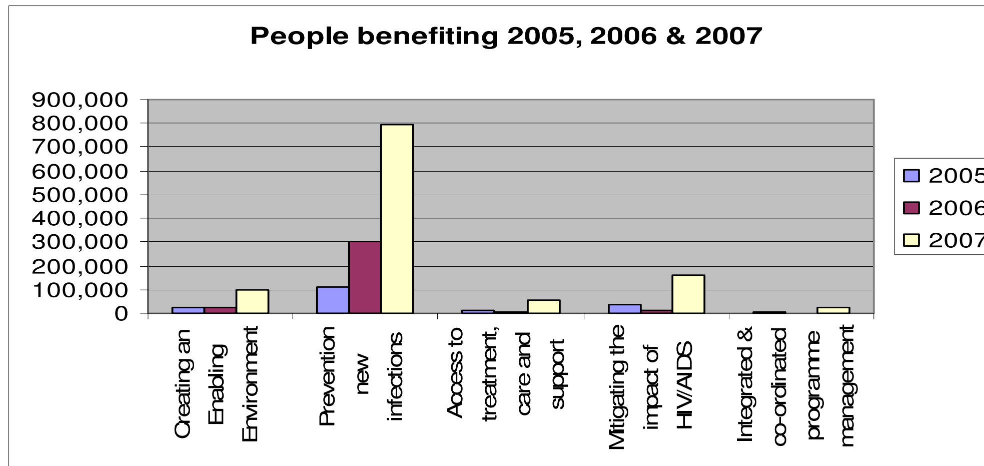
Interpreting the trends in the number of events reported is more difficult, other than to note that the number of events reported in relation to Mitigating the impact of HIV/AIDS appears to be largely static (given that the data set for 2007 is roughly twice that for the previous two years. What is striking is the significant increase in the number of events and the people benefiting from activities associated with the Prevention new infections and, to a lesser extent, in relation to Creating an Enabling Environment and Providing access to treatment, care and support. All of these increases are to be welcomed and almost certainly reflect the impact of strengthened funding to successful organisations on the ground. What is of concern, however, is that the weight of activity when measured from the perspective of events and people is so heavily focused on Prevention new infections. It is to be hoped that this significantly increased activity will have an impact – a challenge given the apparent failure of programmes in the 90s and early years of 2000 – what is of concern is whether sufficient resources are coming through for Mitigating the impact of HIV/AIDS or for Providing access to treatment, care and support.

Table/Graph 14 Overall activity recorded by centres – 2005, 2006 and 2007

Activity area	Number of centres reporting events			% of centres reporting events			Number of events reported			Number of people benefiting in total		
	2005	**2006**	**2007**	**2005**	**2006**	**2007**	**2005**	**2006**	**2007**	**2005**	**2006**	**2007**
Creating an Enabling Environment	79	60	105	74%	50%	50%	595	1,971	5,748	23,684	22,472	98,458
Prevention new infections	57	92	102	53%	77%	48%	3,310	24,311	370,427	112,452	300,061	796,386
Providing access to treatment, care and support	35	39	75	33%	33%	35%	2,010	2,265	15,024	13,951	4,529	54,979
Mitigating the impact of HIV/AIDS	41	50	99	38%	42%	47%	3,304	852	5,871	35,680	10,658	157,211
Integrated & co-ordinated programme management	14	11	77	13%	9%	36%	776	57	3,236	7,268	1,953	27,732
Totals	**107**	**119**	**212**	**100%**	**100%**	**100%**	**9,995**	**29,456**	**400,306**	**193,035**	**339,673**	**1,134,766**

This can also be represented graphically, focussing on the people benefiting from activities.

Table/Graph 15 People benefiting from actions – 2005, 2006 and 2007

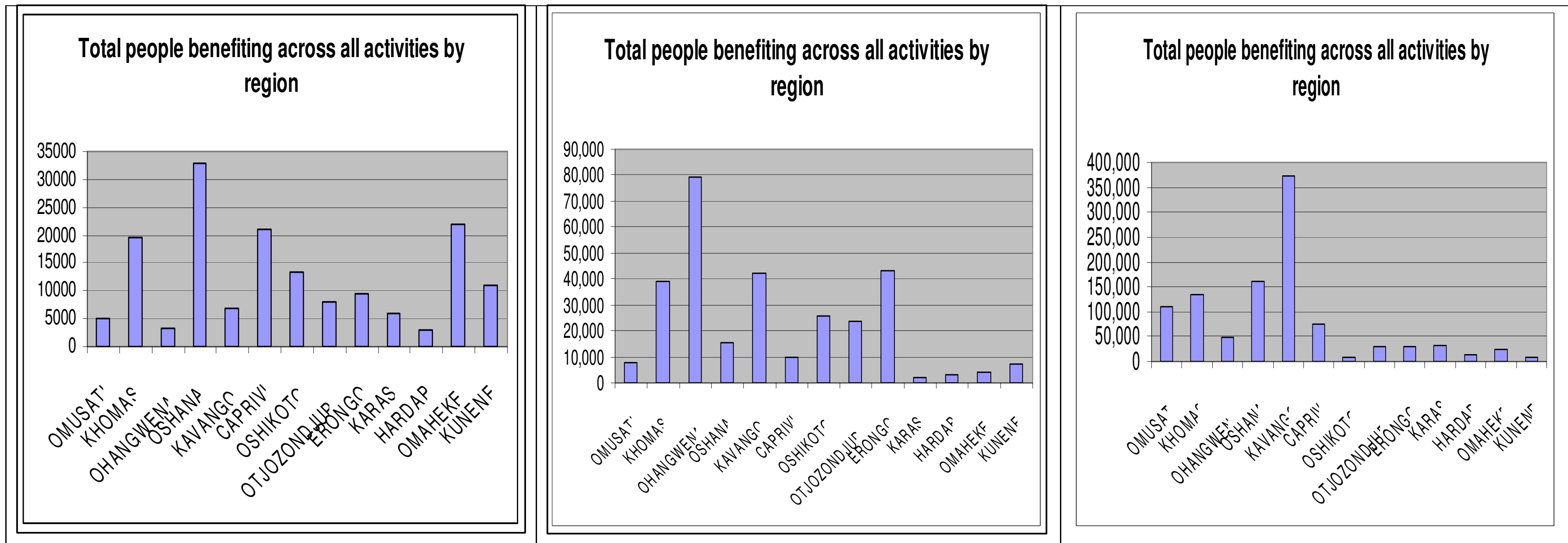


Organisations were asked to indicate their activities down to constituency level in 12 fields that may be described as service areas. For example, within the area of Prevention Activities, data was sought in respect of each of the sub-fields BCI programmes for vulnerable populations, BCI programmes for young people, BCIs in schools, Workplace programmes, Expanding condom provision and Strengthening STI management. The reason for this was that these service areas are delivered on a direct, face to face basis. It is, therefore, important to be able to identify gaps and to target additional interventions accordingly.

In practice, many organisations were only able to describe their activities at a regional level. Indeed, a few were only able to identify numbers at a national level. Thus considerable work is needed to encourage record keeping at a constituency level, in order to maximise the use of scarce resources and target additional resources as effectively as possible. Notwithstanding this, gathering data at constituency level was not entirely unsuccessful. Data was recorded in 2006 in relation to 68 constituencies - 64% of all constituencies in the country. This was nearly double the 36 constituencies for which data was gathered in 2005. What was disappointing was that no further improvement was recorded in 2007, with data being recorded for the same number of 68 constituencies as in 2006.

Table/Graph 16 Total numbers of people benefiting across all activities by region

2005	2006	2007

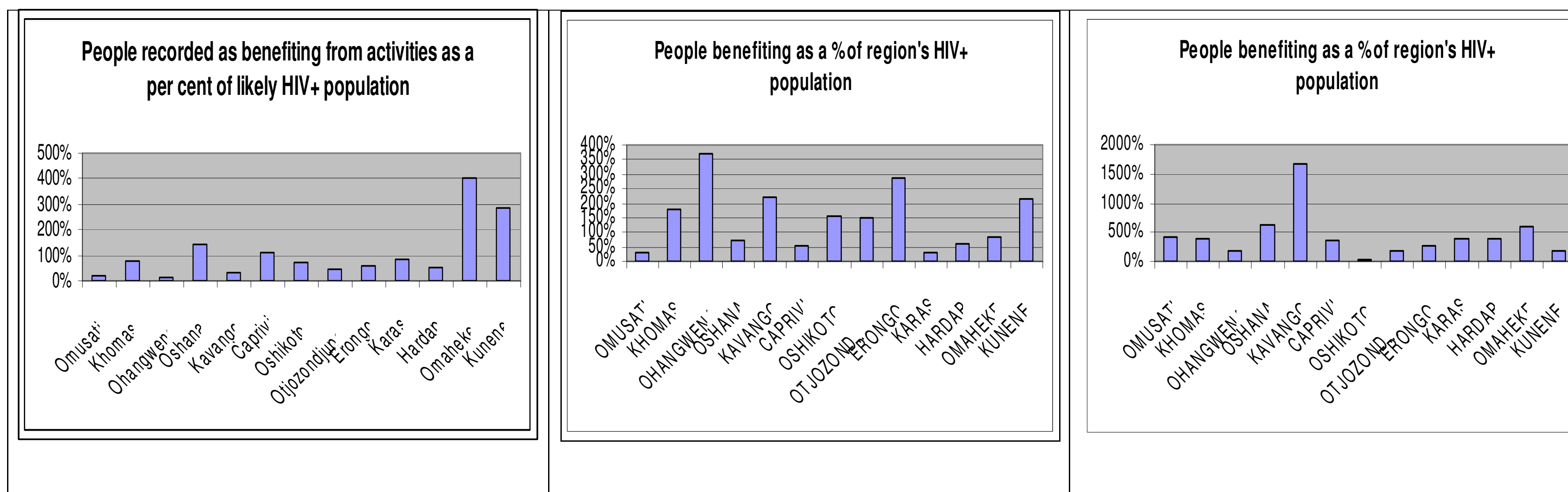


At a regional level, the charts on the previous page demonstrate the numbers of people benefiting in total from interventions of all types. As elsewhere indicated in this report, the numbers benefiting ought to be broadly higher to the left of the chart than to the right. It will be noted that the spread of people benefiting is rather changed when compared with 2005, with the total numbers of people benefiting between in 2006 almost double that of 2005 (195,040 in 2005: 339,673 in 2006). This increase is grows sharply in 2007; although the scale is distorted by the very high figures for Kavango, many areas show an increase in numbers benefiting that is in excess of what might have been expected from the larger data sample for 2007.

Another way of looking at the spread of activities, as it relates to the degree of need in a region, is to chart the total numbers recorded as benefiting from activities is expressed as a percentage of people likely to be HIV+ in a region. This is shown in the charts below and the table overleaf.

Table/Graph 17 Total numbers of people benefiting as a percentage of likely HIV+ people in a region (Charts)

2005	2006	2007



The chart for 2007 is heavily distorted by the data for Kavango, where prevention activities (spread broadly across the range of activities under that heading) are on a scale quite different to that of other regions. But all of the regions most affected show significantly high ratios in excess of the numbers with AIDS in the regions, although Ohangwena and Oshikoto seem to show a falling back in 2007.

Table/Graph 18 Total numbers of people benefiting as a percentage of likely HIV+ people in a region (Table)

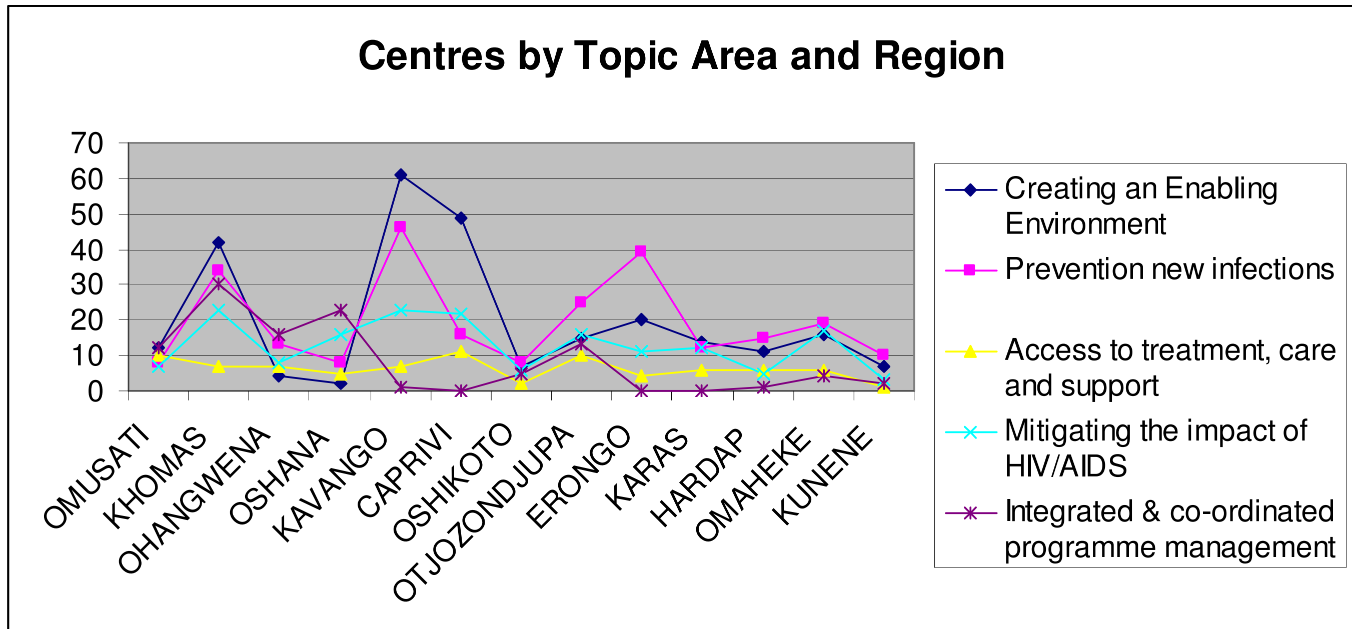
Region	2005	2006	2007
Omusati	19%	30%	407%
Khomas	75%	181%	402%
Ohangwena	13%	367%	170%
Oshana	145%	73%	637%
Kavango	30%	220%	1677%
Caprivi	109%	54%	361%
Oshikoto	73%	156%	37%
Otjozondjupa	44%	146%	185%
Erongo	59%	285%	260%

Karas	83%	32%	382%
Hardap	52%	62%	400%
Omaheke	400%	84%	606%
Kunene	286%	217%	178%
National			

It is also of interest to observe the spread of agencies by activity area across the regions:

Table/Graph 19 Centres by topic area and region

	OMUSATI	KHOMAS	OHANGWENA	OSHANA	KAVANGO	CAPRIVI	OSHIKOTO	OTJOZONDJUPA	ERONGO	KARAS	HARDAP	OMAHEKE	KUNENE
Creating an Enabling Environment	12	42	4	2	61	49	7	15	20	14	11	16	7
Prevention new infections	8	34	13	8	46	16	8	25	39	12	15	19	10
Access to treatment, care and support	10	7	7	5	7	11	2	10	4	6	6	6	1
Mitigating the impact of HIV/AIDS	7	23	8	16	23	22	6	16	11	12	5	17	3
Integrated & co-ordinated programme management	12	30	16	23	1		5	13			1	4	2



The table and graph shows quite some inconsistency in the incidence of activities to tackle HIV/AIDS. Whereas the number of organisations in each region offering Access to treatment, care and support shows a broadly even spread, the spread of organisations working to Create and enabling environment and Prevent new infections bears no resemblance either to the estimated degree of need or a spread which reflects the activities of CBOs based in one community.

3.3 Creating an enabling environment

Organisations were asked "If you work towards an environment where people infected and affected with HIV/AIDS enjoy equal rights in a culture of acceptance, openness and compassion, please tell us about those services".

As a background to this question, the relevant sections of MTP III are represented:

Programme Sub Components, and Outcomes	Ref. no.	Outcome Indicators	Baseline 2004	Short Term Targets Early 2007	Medium term Targets 2009	Responsible Agency
Sub Component 1.1 Capacity development of Leadership						
Outcome 1.1.1 Sustained Leadership Commitment	2 3	The amount of national funds spent by the GRN on HIV/AIDS *annually* * [6] GRN Development Budget (N$'000): Operational expenditure ceiling MoHSS, (N$'000) % of attendance of designated leaders at national and regional HIV/AIDS coordination meetings	73,814 1,575,131 71%	50,000 1,680,956 (2005-06) 80%	- - 90%	**NAC,** GRN, NGOs, FBOs, Private Sector, Development partners
Sub-Component 1.2 Greater Involvement of PLWHA						
Outcome 1.2.1 Greater involvement of PLWHA and vulnerable populations	4 5	# of PLWHAs provided with advocacy and communication skills training % of coordination meetings (all levels) which include PLWHA	- -	50 60%	50 100%	**Lironga Eparu,** PLWHA networks, MoHSS, NGOs
Sub-Component 1.3 Policy and Law Reform						
Outcome 1.3.1 National policy development and law reform	6	National Composite Policy Index	12/20	16/20	20/20	**MoHSS Directorate: Special Programmes,** MoJ, ALU
Outcome 1.3.2 Sectoral and Institutional Policies	7	% of large enterprises/ companies *(including line ministries)* that have HIV/AIDS workplace policies *[7]	Less than 10%	80% 26 sectors with policies	100% 26 sectors implement policies	**All Ministries,** Private sector, Civil society

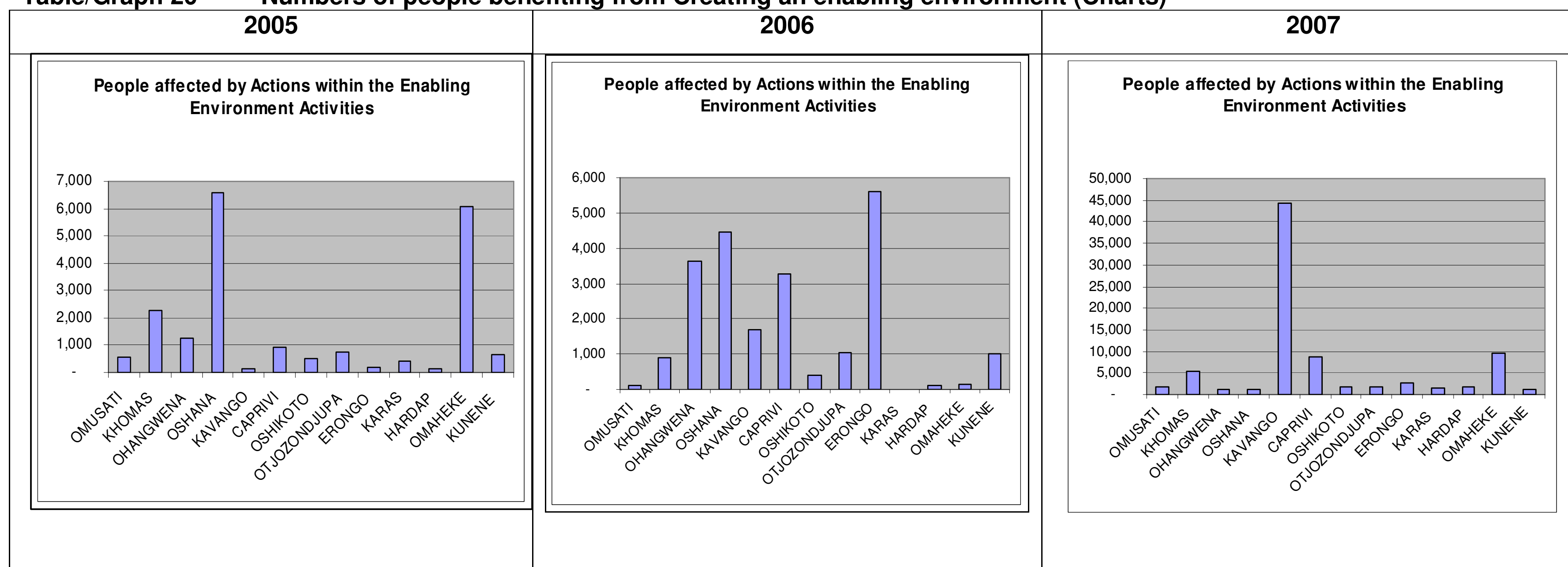
[6] Medium Term Expenditure Framework (2003/04 - 2005/06)

[7] * UNGASS indicator

Programme Sub Components, and Outcomes	Ref. no.	Outcome Indicators	Baseline 2004	Short Term Targets Early 2007	Medium term Targets 2009	Responsible Agency
Sub-Component 1.4 Intervention to reduce Stigma and Discrimination						
Outcome 1.4.1 Social mobilisation to combat discrimination	8	% of population expressing accepting attitudes towards PLWHAs by gender, residence and level of education	-	75%	100%	**MoHSS,** MIB, Lironga Eparu
Outcome 1.4.2 Actions to address stigma & discrimination	9	% of people knowing where to go for legal assistance or counselling regarding stigma and discrimination (DHS)	-	30%	80%	**All Ministries,** MoJ, ALU

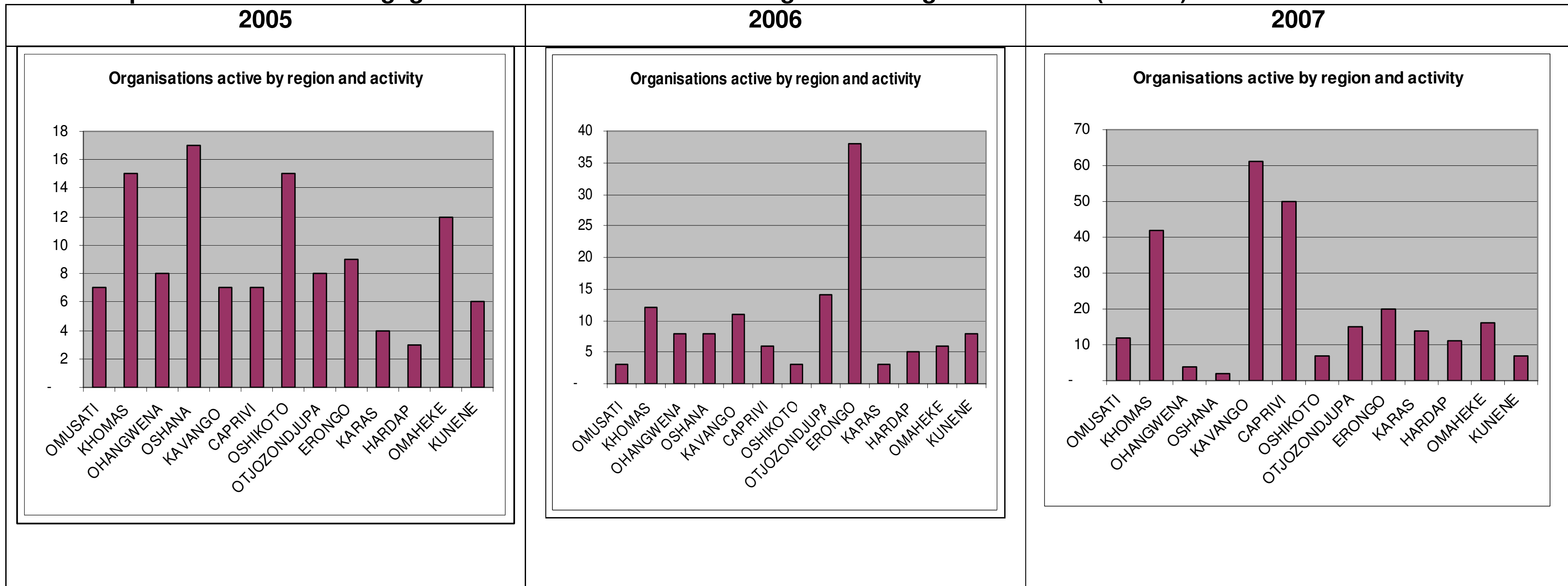
50% of the 212 centres recorded activities in this field – the same percentage as in 2006 and down from the 74% recorded in 2005.

Table/Graph 20 Numbers of people benefiting from Creating an enabling environment (Charts)



However, the number of people recorded as having benefited is significantly higher than in the previous surveys, even allowing for the fact that this 2007 sample is higher than in previous years. This comes out very sharply in relation to the Kavango, where the number of agencies engaged and the number of people seen to have benefitted are sharply up on previous years. Quite why there is such an increase in agency activity in the Kavango in this Enabling field (and in the following activity area, Prevention), is unclear.

Table/Graph 21 Centres engaged in activities towards Creating an enabling environment (Charts)



The proportion of centres engaged in this area of activity was, at 50% for both 2006 and 2007, below the proportion (74%) for 2005. There is no explanation for this difference and the overall number of people reported to be affected was virtually the same between 2005 and 2006. The Kavango figures then drive the figures sharply higher in 2007; without this sharp increase in Kavango the numbers benefitting would be broadly the same as in previous years, given the higher sample of 2007.

All regions continue to report a spread of organisations involved in this area of activity, with only 2 regions (2005: 2; 2006: 3) recording less than 5 organisations involved in this way in their regions. This is important as the whole area of activity should be one where there is a wide spread of activities across the country. It is of concern that it is in Ohangwena and Oshana where the low numbers of agencies are recorded in 2007; in

these regions the numbers of infected people are high and there is a real need, therefore, for leadership, the engagement of PLWHA and actions to reduce discrimination. It is not that organisations were not visited in the two regions, or were not active in the two regions, as can be seen in the later tables – in particular in relation to actions to mitigate the impact of HIV/AIDS; rather it appears that this was not a priority area.

Once again, no activity is recorded in relation to Sectoral and institutional policy development and reform, although the number of centres and activities associated with National policy development and law reform is markedly up from the 2 recorded in the 2006 Report. This reflects, perhaps, the wish of agencies to be practically engaged in actions to tackle HIV/AIDS, although the reality is that well managed policy development and reform can have significant impact on people's actions and activities.

Table/Graph 22 Centres involved in and the number of actions and people benefiting towards an enabling environment in 2007

	Organisations	Actions	People benefiting	OMUSATI	KHOMAS	OHANGWENA	OSHANA	KAVANGO	CAPRIVI	OSHIKOTO	OTJOZONDJUPA	ERONGO	KARAS	HARDAP	OMAHEKE	KUNENE
Sustained leadership commitment	76	652	13,424	80	589	55	-	7,220	3,322	16	104	575	184	196	67	-
Greater involvement of PLWHA	71	869	18,675	320	202	-	-	6,097	1,740	95	233	825	256	419	8,230	37
National policy development and law reform	13	135	2,512	-	1,436	-	-	-	100	-	59	-	-	-	-	-
Sectoral and institutional policy development and reform	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Social mobilisation to combat discrimination	28	202	16,341	1,248	1,617	1,000	1,000	1,850	1,550	1,600	1,121	1,000	1,000	1,000	1,065	1,060
Actions to reduce stigma and discrimination	63	3,840	47,417	93	1,580	93	48	29,119	2,024	116	165	383	202	70	359	93
Other	4	50	89	-	89	-	-	-	-	-	-	-	-	-		-
Total Actions / numbers benefiting		**5,748**	**98,458**	**1,741**	**5,513**	**1,148**	**1,048**	**44,286**	**8,736**	**1,827**	**1,682**	**2,783**	**1,642**	**1,685**	**9,721**	**1,190**
Centres involved	**105**			**12**	**42**	**4**	**2**	**61**	**50**	**7**	**15**	**20**	**14**	**11**	**16**	**7**

Table/Graph 23 Centres involved in and the number of actions and people benefiting towards an enabling environment in 2006

	Organisations	**Actions**	**People benefiting**	**OMUSATI**	**KHOMAS**	**OHANGWENA**	**OSHANA**	**KAVANGO**	**CAPRIVI**	**OSHIKOTO**	**OTJOZONDJUPA**	**ERONGO**	**KARAS**	**HARDAP**	**OMAHEKE**	**KUNENE**
Sustained leadership commitment	52	364	8,614	90	762	3,578	770	3	11	135	341	2,107	-	38	33	566
Greater involvement of PLWHA	38	1,189	5,987	-	136	60	3,665	65	-	-	29	1,581	6	5	12	431
National policy development and law reform	2	2	70	-	-	-	-	-	-	-	70	-	-	-	-	-
Sectoral and institutional policy development and reform	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Social mobilisation to combat discrimination	20	252	6,170	1	1	1	1	892	3,246	-	271	1,600	1	57	106	-
Actions to reduce stigma and discrimination	10	164	1,631	3	3	3	3	722	-	270	343	300	3	-	2	-
Other	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Actions and number of people benefiting		**1,971**	**22,472**	**94**	**902**	**3,642**	**4,439**	**1,682**	**3,257**	**405**	**1,054**	**5,588**	**10**	**100**	**153**	**997**
Centres involved	**60**			**3**	**12**	**8**	**8**	**11**	**6**	**3**	**14**	**38**	**3**	**5**	**6**	**8**

In the 2006 report it was noted that the number of organisations recording actions that reflect a greater involvement of PLWHA was sharply higher at 38, compared with just 6 in 2005. This trend is continued in the 2007 study, with the number of people recorded as benefiting showing an increase well beyond that which might have been expected from the larger sample of 2007. It was observed in the 2005 study that

> "…the driving force for someone to reveal his or her status was often poverty and the need for food. People commented that there were few benefits to be had from revealing their status "If you reveal your status we are promised this and that but these are empty promises - people never come back". Communities need to see the benefit of people coming out publicly; presently the overriding report is that families feel that shame is being brought to the family if someone reveals their status."

One of the possible reasons for the sharp increase in numbers of organisations and activities is that the government has made major progress in providing ARV treatment throughout Namibia, with all regions now being covered. This success is having a significant effect on attitudes towards HIV/AIDS in Namibia, giving people a powerful reason for discovering their own status. There are problems that emerge from this success, with perhaps the biggest being that of inadequate food supplies; these will be discussed later in this Chapter.

Notwithstanding the existence of a real benefit from knowing one's status, the degree of stigma to be found in Namibian society is such that there is still great reluctance among people firstly to know their status and secondly to reveal it. Namibians are a long way from holding a universal understanding of the epidemic to the point where people have no fear as to recognising their status. Thus it is encouraging to note

that Actions to reduce stigma and discrimination show a marked increase on 2006, when the number of actions was counted in the hundreds. In 2007, the number of actions has risen to nearly 4,000 and the numbers benefiting to almost 50,000 (although they were heavily concentrated in Kavango). If this change is sustained, then it is a critical step to better managing the epidemic in Namibia.

3.4 Prevention

Organisations were asked "If you work towards reduced new infections of HIV and other STIs, please tell us about that work".

As a background to this question, the relevant sections of MTP III are represented:

Programme Sub Components, and Outcomes	Ref. no.	Outcome Indicators	Baseline 2004	Short Term Targets Early 2007	Medium term Targets 2009	Responsible Agency
Sub Component 2.1: Strengthen capacity to deliver HIV/AIDS prevention programmes						
Outcome 2.1.1 Capacity Development: Prevention	10	% of schools with teachers who have been trained in life-skills-based HIV/AIDS education and taught it during the last curriculum year by type of school (primary/secondary) * [8] *N.B. The outcome of good other capacity building will be reflected in improved prevention services below*	-	50%	75%	**MoHSS** MIB MBESC
Sub-component 2.3: Target BCI at Young People						
Outcome 2.3.1 Target BCI in schools	13	# of young people taught life-skill-based HIV/AIDS education in past 12 months by type of school and gender	100,000	400,000	500,000	**MBESC** NGOs
Outcome 2.3.2 BCI for Youth	14	% of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission by gender & residence *[9]	+-86% (2000)	95%	99%	**MHETEC** Dir. Adult Education, Further Education Institutions, NGOs
	15	% of people reporting the consistent use of a condom during sexual intercourse with a non-regular sexual partner by gender, residence & age 5-24 *				
		women 15-19 age group	48.5%[10]	60%	80%	
		women 20-24 age group	38%	50%	60%	
	16	Median age at first sex among 20-24 year-olds by gender & residence				
		men 20-24 age group	16.7	17.5	19	
		women 20-24 age group	18.2	19	20	
Sub-component 2.4: Target the General Population						

[8] * UNGASS Indicator

[9] * UNGASS Indicator

[10] DHS 2000, p177 % of women who have had sexual intercourse in the past year who used a condom during last sexual intercourse with any partner.

Programme Sub Components, and Outcomes	Ref. no.	Outcome Indicators	Baseline 2004	Short Term Targets Early 2007	Medium term Targets 2009	Responsible Agency
Outcome 2.4.1 Social Mobilisation and Awareness	17	% of sexually active respondents who had sex with a non-regular partner within the previous 12 months by gender[11]	19%	17%	15%	**MIB** All Key Actors
Outcome 2.4.2 Workplace programmes	18 19	% of large enterprises/companies *(incl line ministries)* that have HIV/AIDS workplace programmes * # of employees in all sectors that have been reached by work place programmes	# 36 -	80% 60,000 public 20,000private	90% 90,000 public 35,000 private	**OPM** MoHSS, NABCOA
Outcome 2.4.3 Expand condom provision	20 21 22	# of male and female condoms distributed through social marketing annually # of male and female condoms distributed free through public sector *(annually)* % of people reporting the consistent use of a condom during sexual intercourse with a non-regular sexual partner by gender, residence & age (15-19, 20-24, 25-29)* women 25-29 age group [12] women 30-39 age group women 40-49 age group	3,780,000 15,000,000 (2001) 34%[13] 19% 9%	4,500,000 40,500,000 45% 25% 15%	5,105,800 - 55% 32% 20%	**MoHSS** NaSoMa, SMA, All Key Actors: NGOs, All Ministries, Private Sector
Outcome 2.4.4 Strengthen STI management	23	% of patients with STIs at health care facilities who have been diagnosed, treated, and counselled according to national management guidelines * [14]	-	75%	95%	**MoHSS** Directorate: Special Programmes,
Outcome 2.4.5 VCT	24 25	# of health facilities that apply national standards for voluntary counselling & testing * # of clients tested for HIV and receiving their sero-status results by region, gender and age group per annum	6 9,900	13 28,000	45 30,800	**MoHSS** Church-based Health Services, NGOs, Private Sector
Sub-component 2.5: Interventions to reduce vulnerability						
Outcome 2.5.1 Addressing vulnerability	27	# and types of interventions by region	13	26	52	**MWACW,** NGOs, Traditional and Local Authorities,

[11] DHS 2000 p174

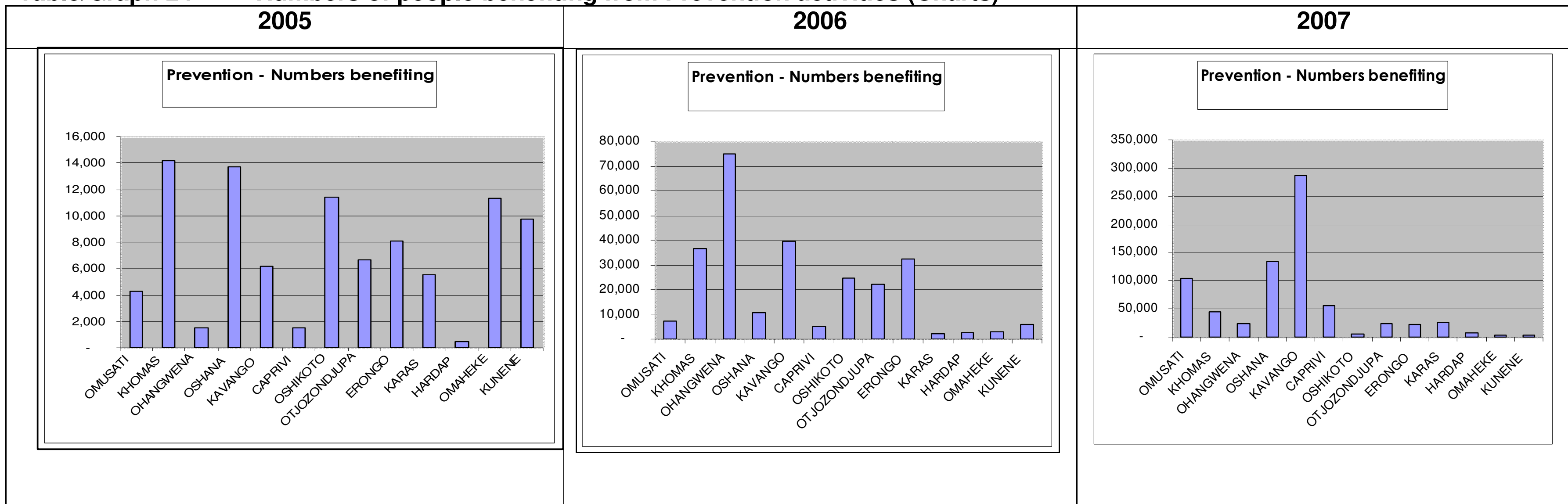
[12] Under 24s are monitored in section 2.2.3 above

[13] DHS 2000, p177 % of women who have had sexual intercourse in the past year who used a condom during last sexual intercourse with any partner.

[14] * UNGASS Indicator

The increase in numbers reported as benefiting from Prevention in 2006 is maintained into 2007. The higher reported figures for condom distribution in 2006 are also maintained into 2007[15], with numbers up at least in line with the larger sample of 2007. Additionally, 2007 reveals a more than expected increase in Social mobilisation and awareness.

Table/Graph 24 Numbers of people benefiting from Prevention activities (Charts)

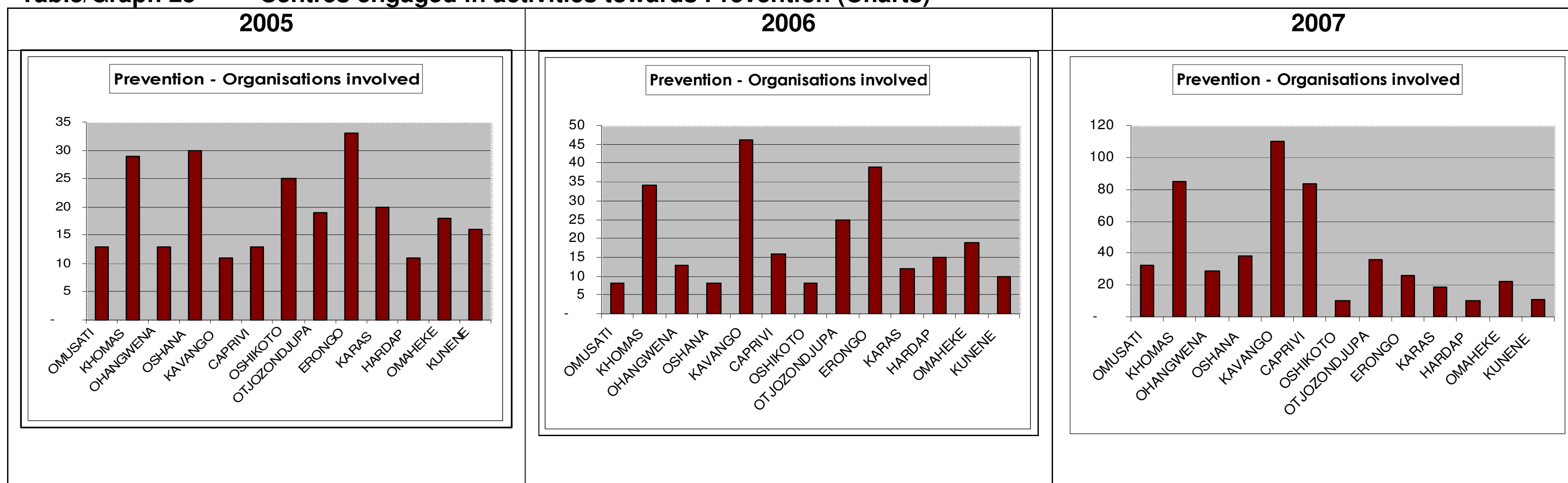


The increase in numbers reported as benefiting shows clearly in the graphs by region. The graphs have to be read carefully, as the scale rises sharply over the 3 years, with top figures per region being just over 14,000 in 2005, 70,000 in 2006 and 280,000 in 2007. Similarly, the number of organisations reporting activity is up in 2007 at least in line with the expectation of the higher sample.

As noted in the 2006 Report, the reason for this increase in activity is most likely to be found in the fact that the Global Funds, awarded in 2002, finally came on full stream in 2006. Certainly, members of the research teams record this as an observation of some of the people responding to the questionnaire.

[15] The survey recording methods have proved problematic in relation to the numbers of condoms distributed and the number of events recorded, with marked differences between organisations. In 2006 and 2007, where it appeared that each condom was being recorded as a separate activity, the number of people benefiting was arrived at by reducing the number of condoms by a factor of 30 and the number of events was arrived at by reducing the number of condoms by a factor of 100.

Table/Graph 25 Centres engaged in activities towards Prevention (Charts)



One area of particularly sharp increase recorded in 2006 was the strengthening of STI management, with new programmes emerging that teach individuals and communities about the relevance of STIs to the HIV/AIDS epidemic and the importance of controlling the spread of STIs. The numbers reported as benefiting in 2006 rose to 69,731 from 1,951 in 2005. What is surprising is that the 2007 data more or less falls back to the levels recorded in 2005. This is accounted for by the fact that DAPP's large prevention programme that came into programme in 2006 does not record activity in this field in 2007; this is probably the result of a difference in recording rather than a material fact on the ground.

Another area of growth in 2006 was the numbers reported as benefiting from VCT - nearly doubling from 11,060 to 18,399, reflecting both the continued development of VCT centres by CSOs and a greater preparedness of individuals to know their status as ARV treatment comes on stream. However, the upward trend is not continued in the 2007; this may be an indication that the numbers have reached a plateau.

Three specific areas for behaviour change interventions are identified in MTP III, alongside the heading "Social Mobilisation and awareness" (Behaviour change intervention programmes for vulnerable populations, for young people and in schools). The rising trend of activity in these fields was sustained into 2007, with the overall total numbers reported as benefiting rising by 50% between 2005 and 2006 (from 62,515 in 2005 to 92,198) and rising further to 460,000 in 2007. Again, caution has to be expressed in relation to this sharp increase, given the much higher sample size in 2007, but it is clear that there is real and sustained growth in this area.

A striking increase in activity lies in the Strengthen capacity to deliver prevention programmes field, where some 80,000 people were reported as benefiting. However, most of this activity is recorded in just 2 regions – Kavango and Caprivi – and the numbers for other regions are much more modest; What is interesting about the Kavango and Caprivi figures is that they are not confined to one or two organisations with larger programmes but are spread across a large number of organisations; thus they are not simply a sampling quirk.

Workplace programmes show a rise in activity in 2007, compared with a fall in 2006. However, the number of activities and the number of people benefiting remain small and it remains a much neglected area, implying that organisations are not meeting their own organisational obligations, quite apart from contributing to a better awareness of the issue in other organisations.

The overall data sets are on the following pages.

Table/Graph 26 Centres involved in and the number of actions and people benefiting in relation to prevention activities in 2007

	Organisations	Events	Number of People benefiting	OMUSATI	KHOMAS	OHANGWENA	OSHANA	KAVANGO	CAPRIVI	OSHIKOTO	OTJOZONDJUPA	ERONGO	KARAS	HARDAP	OMAHEKE	KUNENE
Strengthen capacity to deliver prevention programmes	76	6,239	80,805	370	5,484	151	34	31,215	33,111	79	1,128	4,200	4,274	30	165	986
BCI programmes - vulnerable populations	48	6,076	50,379	422	6,756	-	-	39,031	1,667	200	788	140	-	-	665	674
BCI programmes - young people	79	6,845	74,275	2,845	11,863	55	65	32,543	4,723	-	972	13,607	1,306	775	473	916
BCI programmes – schools	70	4,294	60,052	1,876	282	2,723	6,737	31,120	5,358	-	1,137	1,180	252	5,765	570	86
Social mobilisation and awareness	83	13,246	286,450	81,382	2,755	2,689	96,447	92,999	3,445	43	2,736	3,024	-	-	633	-
Workplace programmes	19	85	2,944	242	813	-	-	455	130	60	90	-	-	-	16	-
Expand condom provision	73	20,743	206,139	14,611	3,740	17,372	28,427	57,477	4,960	951	16,408	-	20,000	-	1,100	1,600
Strengthen STI management	9	127	4,124	-	2,789	-	-	-	250	-	20	-	-	-	-	-
VCT	39	11,971	18,901	866	3,223	1,541	1,792	1,469	1,056	3,298	470	812	203	440	-	-
Addressing vulnerability based on gender, violence & alcohol abuse	23	288	11,867	2,000	7,792	200	350	-	473	-	300	-	-	-	361	-
Other	1	10	450	45	45	45	-	45	-	45	45	45	45	-	45	45
Activities		**69,923**	**796,386**	**104,659**	**45,542**	**24,776**	**133,852**	**286,354**	**55,173**	**4,676**	**24,094**	**23,008**	**26,080**	**7,010**	**4,028**	**4,307**
Centres involved	**102**			**32**	**85**	**29**	**38**	**110**	**83**	**10**	**36**	**26**	**19**	**10**	**22**	**11**

Table/Graph 27 Centres involved in and the number of actions and people benefiting in relation to prevention activities in 2006

	Organisations	Events	Number of People benefiting	OMUSATI	KHOMAS	OHANGWENA	OSHANA	KAVANGO	CAPRIVI	OSHIKOTO	OTJOZONDJUPA	ERONGO	KARAS	HARDAP	OMAHEKE	KUNENE
Strengthen capacity to deliver prevention programmes	21	208	9,820	1	623	1	2	1	20	106	8,787	1	3	103	69	1
BCI programmes - vulnerable populations	14	728	3,400	-	130	-	-	15	-	375	2,167	300	1	56	350	6
BCI programmes - young people	34	266	17,853	1,095	6,225	102	604	1,821	210	-	3,446	2,703	1	18	408	1,120
BCI programmes - schools	27	331	8,889	-	35	4,298	5	1,878	675	-	174	919	-	5	-	900
Social mobilisation and awareness	61	626	62,056	351	1,588	25,212	91	16,136	2,348	8,494	2,215	4,775	-	1,005	287	1
Workplace programmes	6	21	304	-	145	-	-	55	-	-	80	-	8	16	1	-
Expand condom provision	34	10,237	104,805	2,135	22,382	2,582	8,812	4,463	1,138	1,655	4,029	18,873	1,790	780	1,626	2,862
Strengthen STI management	5	94	69,371	-	50	41,551	-	13,850	-	13,850	-	-	1	-	68	-
VCT	16	11,680	18,399	3,785	3,017	1,269	1,289	1,176	330	-	1,032	3,721	211	659	-	-
Addressing vulnerability based on gender, violence & alcohol abuse	9	115	5,124	-	2,454	-	-	-	360	-	-	1,145	92	-	166	1,000
Other	1	5	40	-	-	-	-	40	-	-	-	-	-	-	-	-
Activities		**24,311**	**300,061**	**7,367**	**36,649**	**75,015**	**10,803**	**39,436**	**5,081**	**24,480**	**21,930**	**32,437**	**2,107**	**2,642**	**2,975**	**5,890**
Centres involved	**92**			**8**	**34**	**13**	**8**	**46**	**16**	**8**	**25**	**39**	**12**	**15**	**19**	**10**

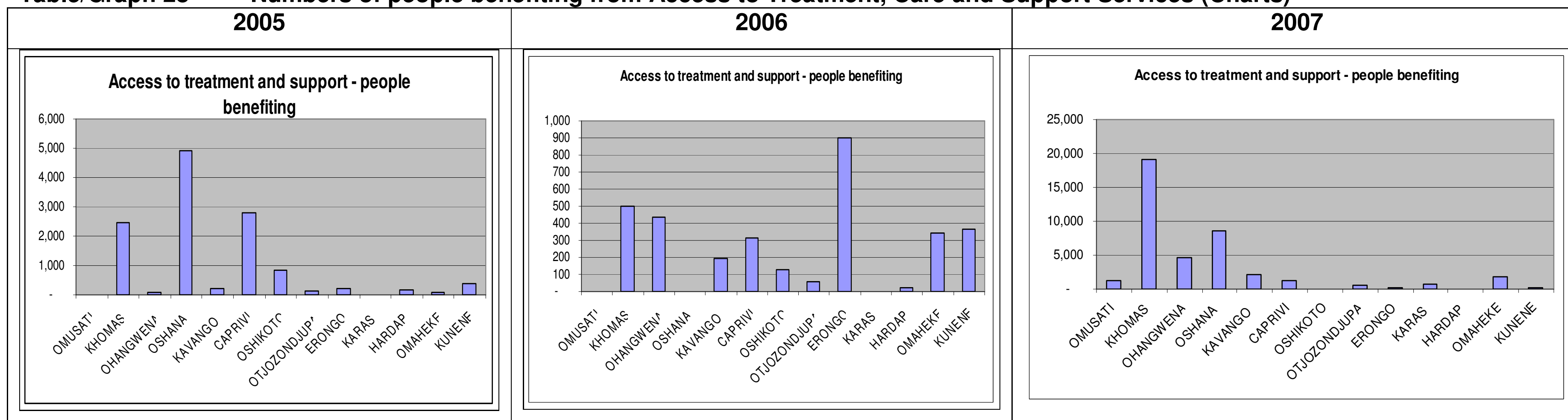
3.5 Access to Treatment, Care and Support Services

Organisations were asked "If you provide access to cost effective and high quality treatment, care and support services for people living with, or affected by HIV/AIDS, please tell us about those programmes".

As a background to this question, the relevant sections of MTP III are represented:

Programme Sub Components, and Outcomes	Ref. No.	Outcome Indicators	Baseline 2004	Short Term Targets Early 2007	Medium term Targets 2009	Responsible Agency
Sub Component 3.1: Capacity Development for the expanded treatment, care and support response						
Outcome 3.1.1 Capacity development of treatment, care and support service providers	28	# of service providers trained per district to implement, monitor & supervise comprehensive case management including HAART (includes clinicians, nurses, pharmacists, technologists & counsellors)	150	325	900	**MoHSS** Church- based Health Services, NGOs, Private Sector
	29	# of home based care providers trained to provide training & support to family members on HAART	2500	6,600	8,000	
	30	# of community volunteers/members/ caregivers trained in providing care and support to orphans and other vulnerable children by region *N.B A considerable range of training is planned the outcomes of which will be reflected in improved treatment, care and services below*	1,500	4,600	6,000	
Sub Component 3.2: Treatment and Care Services						
Outcome 3.2.5 Collaborative TB/HIV/AIDS services	38	% of TB patients tested for HIV and counselled each year	< 5%	50%	90%	**MoHSS** Church- based Health Services,, NGOs
	39	TB treatment success rate	69%	75%	85%	
	40	# of TB patients on HAART	100	1,500	3,500	
Outcome 3.2.7 Home Based Care	43	# of community volunteers & caregivers providing home based care by district & constituency	2,500	6,600	8,000	**MoHSS** NGOs
	44	% of chronically ill clients receiving home based care, by gender & district	35%	70%	95%	

Table/Graph 28 Numbers of people benefiting from Access to Treatment, Care and Support Services (Charts)



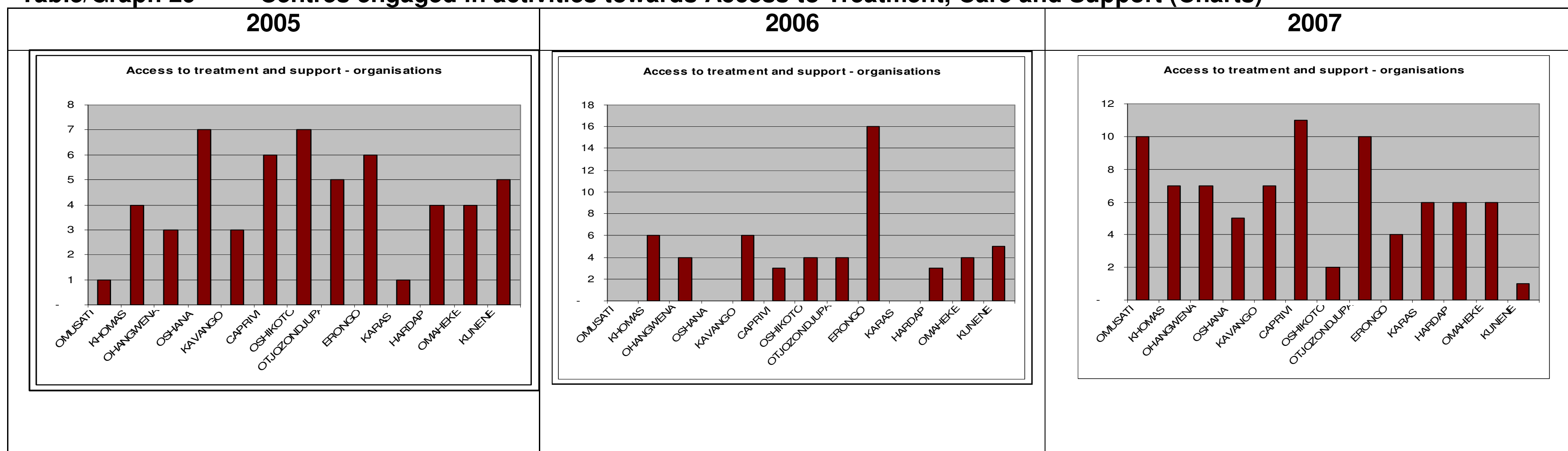
The level of activity reported between 2005 and 2006 in relation to Treatment, care and support showed only a small increase in organisations and activities. So, in 2005, 35 organisations reported 2,010 activities which benefited 13,951 people. In 2006, 39 organisations record 2,265 activities benefiting 4,529 people. The 2007 figures, however, show strong growth, in excess of the simple fact of the larger sample, with the growth taking place almost entirely in home-based care.

One relevant factor for lower activity levels in 2006 may have been the fact that the Small Grants Fund did not make any new allocations in 2006. But it is difficult to discern any real pattern in the figures between 2006 and 2007, with some regions showing strong growth in activity based on a similar number of organisations being involved in the two years, with other regions showing similar levels of activity even when the number of organisations involved has changed markedly.

The biggest area of unexpected change between 2006 and 2007 is the number of people benefitting from care in 2007 in Khomas, with Ohangwena and Oshana also recording big increases. That for Khomas arises from the inclusion of one new centre (Catholic AIDS Action) in the data set in 2007, while in Ohangwena and Oshana the figures appear to be more organic in growth.

Table/Graph 29 Centres engaged in activities towards Access to Treatment, Care and Support (Charts)

2005	2006	2007



Table/Graph 30 Centres involved in and the number of actions and people benefiting in relation to access to support in 2007

	Organisations	Events	People	OMUSATI	KHOMAS	OHANGWENA	OSHANA	KAVANGO	CAPRIVI	OSHIKOTO	OTJOZONDJUPA	ERONGO	KARAS	HARDAP	OMAHEKE	KUNENE
Expanding treatment care & support	9	205	6,652	-	-	-	-	-	-	-	-	-	-	-	-	-
Collaborative TB/HIV/AIDS services	9	172	1,369	188	140	828	-	-	-	-	213	-	-	-	-	-
Home based care	74	14,317	39,949	1,075	18,988	3,794	8,639	2,127	1,201	42	280	165	709	18	1,767	150
Other	6	330	7,009	-	-	-	-	-	-	-	-	45	-	-	-	-
Total Activities		**15,024**	**54,979**	**1,263**	**19,138**	**4,622**	**8,639**	**2,127**	**1,201**	**42**	**493**	**210**	**709**	**18**	**1,767**	**150**
Centres Involved	**75**			**10**	**7**	**7**	**5**	**7**	**11**	**2**	**10**	**4**	**6**	**6**	**6**	**1**

Table/Graph 31 Centres involved in and the number of actions and people benefiting in relation to access to support in 2006

	Organisations	Events	People	OMUSATI	KHOMAS	OHANGWENA	OSHANA	KAVANGO	CAPRIVI	OSHIKOTO	OTJOZONDJUPA	ERONGO	KARAS	HARDAP	OMAHEKE	KUNENE
Capacity development for expanded treatment care and support	7	362	521	-	-	-	-	-	128	-	-	-	-	-	-	-
Collaborative TB/HIV/AIDS services	6	15	475	-	160	-	-	-	-	-	40	237	-	-	38	-
Home based care	42	1,737	2,868	-	343	438	-	196	186	127	14	661	-	19	304	365
Other	2	151	665	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Activities		**2,265**	**4,529**	**-**	**503**	**438**	**-**	**196**	**314**	**127**	**54**	**898**	**-**	**19**	**342**	**365**
Centres Involved	**39**			**-**	**6**	**4**	**-**	**6**	**3**	**4**	**4**	**16**	**-**	**3**	**4**	**5**

3.6 Impact mitigation services

Organisations were asked "If you work towards strengthened and expanded capacity for local responses to mitigate socio-economic impacts of HIV/AIDS, please tell us about those programmes".

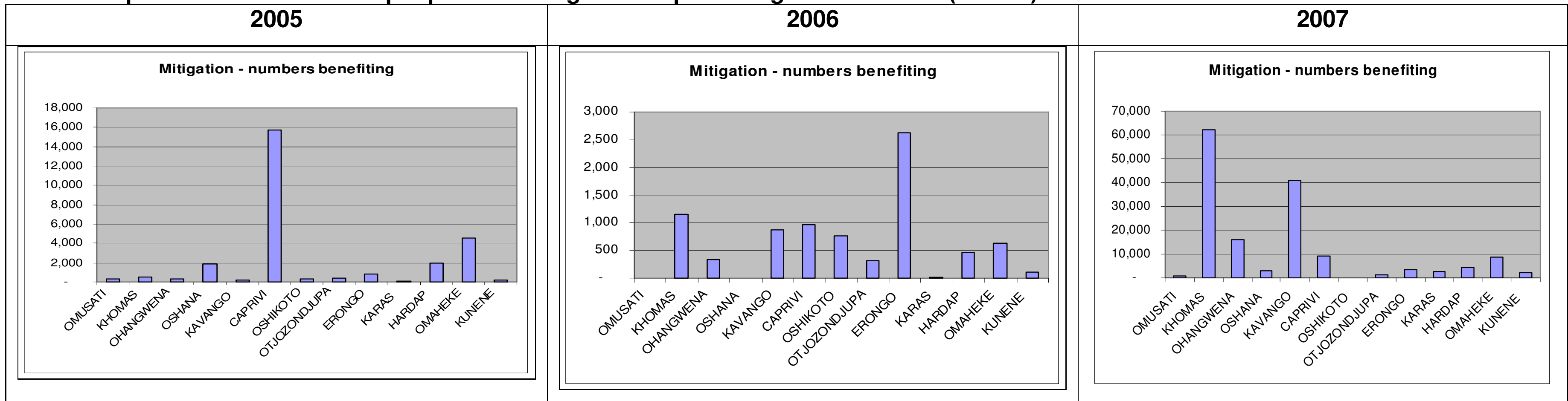
As a background to this question, the relevant sections of MTP III are represented:

Programme Sub Components, and Outcomes	Ref. No.	Outcome Indicators	Baseline 2004	Short Term Targets Early 2007	Medium term Targets 2009	Responsible Agency
Sub-component 4.1: Developing the Capacity of Local Responses						
Outcome 4.1.1 Developing capacity for community-based responses	45	% of constituencies implementing HIV/AIDS community action plans,	-	60/96	80%	**Councillors,** MWACW, MBESC, CAFO, CAA, NGOs
Outcome 4.1.2 Developing the capacity of support groups for PLWHA	46	# of PLWHAs provided with skills training to manage support groups	-	100	150	**NGOs**
	47	% of constituencies with support groups	-	50%	90%	
Sub-Component 4.2: Services for OVC and PLWHA						
Outcome 4.2.1 Services for OVC and PLWHA	48	# and % of households with OVC that have received support through grants (maintenance & foster parent grants) from the government	10,813	30% increase	80% increase	**MWACW** NGOs, MBESC CAFO, CAA
	49	Ratio of current school attendance among orphans to that of non-orphans *	-	1 (0 difference)	1 (0 difference)	
	50	# of OVC and PLWHA enrolled in community based care and support projects	<20	1000	1610	
	51	Number of PLWA receiving disability/social grants	X[16]	-	-	
Sub Component 4.3: Addressing poverty						
Outcome 4.3.1 Addressing poverty, food security, nutrition and housing	52	# of local groups of HIV affected people trained in income generating skills training by region	2	260	500	MAWRD, MBESC, MoHSS, CAFO, KAYEC, CAA OPM, Governors
	53	# of orphans and vulnerable children receiving material & psychosocial support, food, by gender & region	-	50,000	100,000	

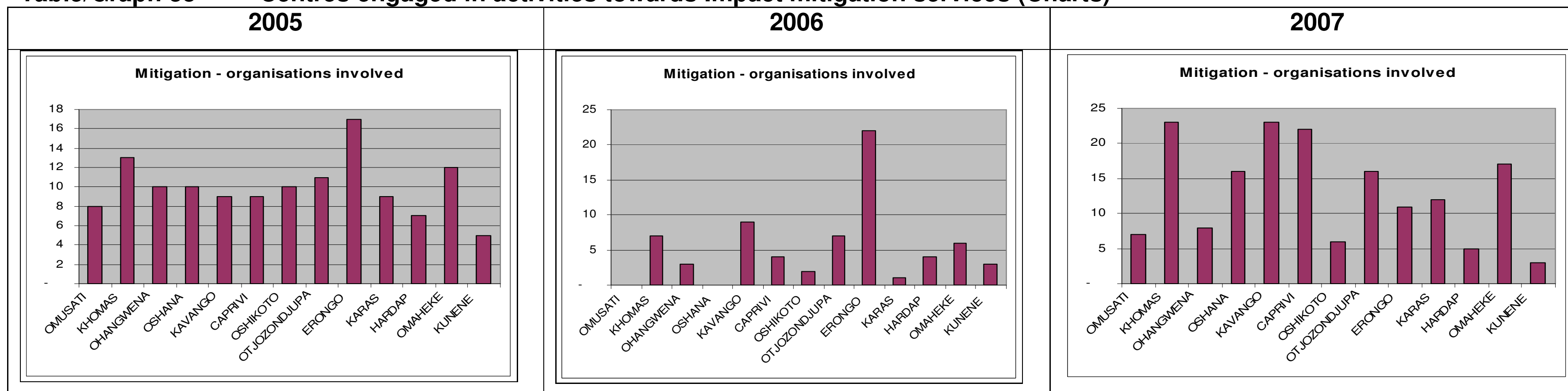
[16] 14,730 people claim the disability grant nationwide for many kinds of disability but this is not disaggregated at national level.

Just as is the case for Treatment, care and support, the area of Impact mitigation services showed signs of reduced activity between 2005 and 2006, with this trend being sharply reversed in 2007. Again, the increase in the number of organisations reporting activity is in line with the larger sample of 2007 (2005:41; 2006: 50; 2007: 99). What is surprising is the sharp increase in the number of activities (2005: 3,304; 2006: 802; 2007: 5,871) and the number of people benefiting (2005: 35,860; 2006: 10,658; 2007: 157,211). The main areas showing an increase are Comprehensive services for OVC, carers & PLWHA and Addressing poverty, food security, nutrition & housing. This latter area of growth probably reflects the fact that ARV treatment is now giving people a real opportunity to manage the virus, confronting many with the problems of food and food security since people need adequate amounts of food and better nutrition if they are going to be able to sustain ARV treatment and gain the full benefit of treatment.

Table/Graph 32 Numbers of people benefiting from Impact mitigation services (Charts)



Table/Graph 33 Centres engaged in activities towards Impact mitigation services (Charts)



This concern for food security and income is reflected in a sample of comments made to the survey teams:

"They do needle work as a means of sustainability and they need more help for it to make a meaningful contribution to the day care centre;
"The buddies cover the programme of treatment and food and nutrition by spearheading and ensuring adherence;
"IGA is part of their programme, buying seeds for schools with water who cater for the OVC are assisted with tanks to plant sweet potatoes and cassava. They need to decentralise to go were there is water;
"They need food for OVC and HBC and also income generating programme and training;
"They are running house-hold gardening, community gardening, and grocery sales, the support they give is a result of money coming from the Africa Group of Sweden;
"Gardening and farming although lack of water is causing serious problems;
"5 Soup Kitchens - one in each in Kuisebmund, Narravile, Swakopmund , Omaruru, Karibib - managed but not funded by the CAA;
"They have income generating programme for the soup kitchen with some cattle but it is not dong well; the gardening projects fail due to lack of fencing;
"They have a poultry, farming and gardening project but they need water;
"The committee has collected clothes in the community and given them to the orphans;
"Three parishes are have gardening programmes;
"The support group of Rehoboth makes soup as an income generating project to assist in various programmes;
"The problem here is that they only give food once per day and it is not nutritious, because you need to eat three times per day. They only provide porridge;

"The group has a garden which needs to be fenced and needs other resources. They are appealing for help because this will serve as income generating and ensure sustainability;
"Gardening and Sewing are the programmes but they need more resources to help the programmes to flourish;
"They are planning a programme with Project of Hope which will cover micro finances;
"They have a needlework programme and a small garden;
"Gardening and Basket making are their income generating activities;
"Making tickets and programmes and are currently in organising a beauty contest"

The need for support from government (as opposed to international donors) is critical, particularly through the state income support that should be available to orphans. This support is modest but important. Many community based organisations give their support for orphans through feeding programmes and similar activities, often using local funds or gifts in kind. The modest income support grants that are officially available for orphans should be an important complement for this local support. However the government revealed in April 2007 that only 46% of registered orphans (64,777) currently benefit from grants, at a cost of N$10.6m. Moreover, support for those children who have lost both parents as a result of the epidemic is almost impossible to come by because of the need to go through formal court child care procedures. This is an area that needs urgent attention.

Table/Graph 34 Organisations involved in and the number of actions and people benefiting in relation to impact mitigation in 2007

	Organisations	Events	Number of People benefiting	OMUSATI	KHOMAS	OHANGWENA	OSHANA	KAVANGO	CAPRIVI	OSHIKOTO	OTJOZONDJUPA	ERONGO	KARAS	HARDAP	OMAHEKE	KUNENE
Establish, strengthen & support communities & their response	19	196	2,874	171	216	207	1	360	750	-	171	-	-	-	548	-
Develop capacity of local support groups of PLWHA & their families	22	435	2,918	26	770	-	221	892	683	1	215	-	-	-	110	-
Comprehensive services for OVC, carers & PLWHA	81	4,599	48,555	233	6,964	2,552	2,694	17,571	3,864	34	398	2,260	2,095	4,127	3,113	16
Addressing poverty, food security, nutrition & Housing	55	637	102,224	-	54,184	13,128	278	21,967	3,828	9	546	1,138	469	8	4,557	2,112
Other	2	4	640	340	-	-	-	-	-	-	-	-	-	-	300	-
Total numbers of events and people benefiting		**5,871**	**157,211**	**770**	**62,134**	**15,887**	**62,134**	**40,790**	**9,125**	**44**	**1,330**	**3,398**	**2,564**	**4,135**	**8,628**	**2,128**
Organisations	**99**			**7**	**23**	**8**	**16**	**23**	**22**	**6**	**16**	**11**	**12**	**5**	**17**	**3**

Table/Graph 35 Organisations involved in and the number of actions and people benefiting in relation to impact mitigation in 2006

	Organisations	Events	Number of People benefiting	OMUSATI	KHOMAS	OHANGWENA	OSHANA	KAVANGO	CAPRIVI	OSHIKOTO	OTJOZONDJUPA	ERONGO	KARAS	HARDAP	OMAHEKE	KUNENE
Establish, strengthen & support communities & their response	10	21	1,206	-	100	-	-	18	-	-	39	400	-	1	470	-
Develop capacity of local support groups of PLWHA & their families	10	41	1,241	-	584	-	-	40	-	-	-	241	-	20	-	-
Comprehensive services for OVC, carers & PLWHA	37	462	5,347	-	208	322	-	633	621	376	5	1,023	-	449	115	113
Addressing poverty, food security, nutrition & housing	19	325	2,814	-	255	12	-	128	351	385	281	965	12	-	45	-
Other	1	3	50	-	-	-	-	50	-	-	-	-	-	-	-	-
Total numbers of events and people benefiting		**852**	**10,658**	**-**	**1,147**	**334**	**-**	**869**	**972**	**761**	**325**	**2,629**	**12**	**470**	**630**	**113**
Organisations	**50**			**-**	**7**	**3**	**-**	**9**	**4**	**2**	**7**	**22**	**1**	**4**	**6**	**3**

3.7 Integrated and co-ordinated Programme Management at all levels

Organisations were asked "If you work towards effective management structures and systems, optimal capacity and skills, and high quality programme implementation at national, sectoral, regional and local levels, please tell us about those programmes".

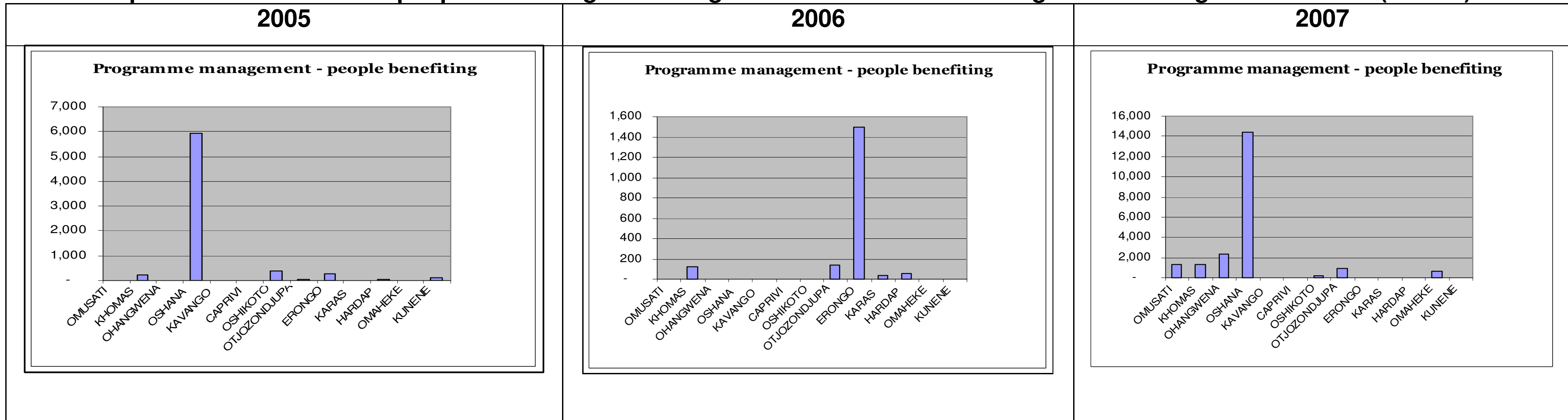
As a background to this question, the relevant sections of MTP III are represented:

Programme Sub Components, and Outcomes	Ref. No.	Outcome Indicators	Baseline 2004	Short Term Targets Early 2007	Medium term Targets 2009	Responsible Agency
Sub-component 5.1 Developing HIV/AIDS Management Capacity						
Outcome 5.1.2 Human resource development[17]	55	# of planners & managers of implementing partners trained in HIV/AIDS programme management and M&E, by sector, by region	10%	80%	95%	**MoHSS,** All Key Actors
Outcome 5.1.4 Institutional Capacity development of NGO service providers	56	# of planners & managers of implementing partners trained in HIV/AIDS programme management and M&E, by sector, by region	10%	80%	95%	**MoHSS,** All Key Actors
Sub-component 5.2 Management and Coordination						
Sub component 5.3: Programme monitoring and evaluation						
Outcome 5.3.1 Monitoring and Evaluation	62	% of organisations that have submitted the required number of completed MoHSS Directorate: Special Programmes Activity Reports on time in the past 12 months	-	95%	100%	**All implementing Partners**
Sub component 5.4 Surveillance and operational research						

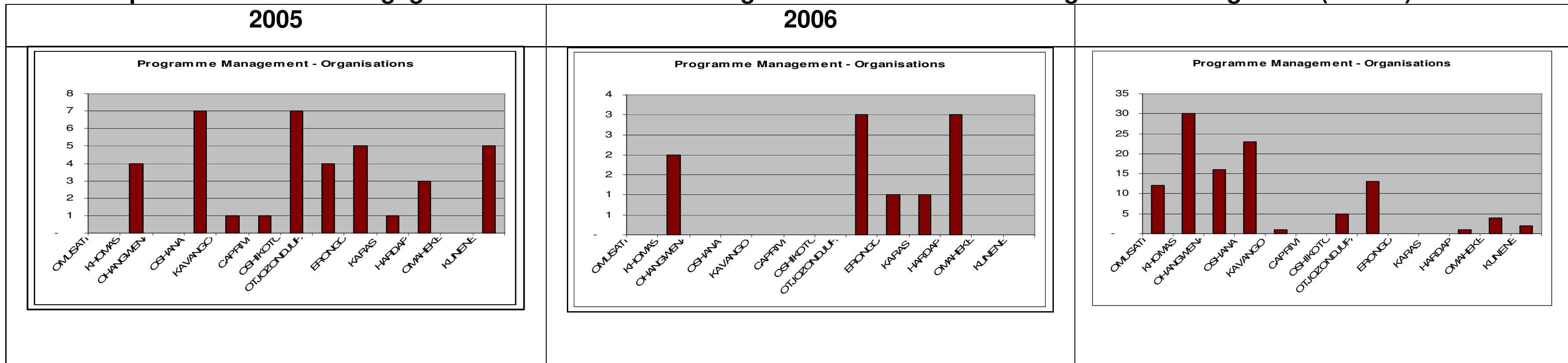
The figures in this area of Integrated and co-ordinated Programme Management at all levels are much higher than might have been expected as a result of the bigger sample between 2006 and 2007. Partly this is the result of one single activity report in relation to Oshana, affecting 12,000 people. But this single activity obscures the much larger number of organisations reporting and the much larger number of events overall. The increase appears to arise from the fact that people are much more aware of the need for Capacity building, Management and Co-ordination and Programme monitoring and evaluation both within as well as outside their organisations. Thus organisations appear to be reflecting their internal co-ordination activities between regions and centre in their data reporting as well as activities in the community.

[17] Indicators which reflect capacity developed under the other components are not reflected here again

Table/Graph 36 Numbers of people benefiting from Integrated and co-ordinated Programme Management actions (Charts)



Table/Graph 37 Centres engaged in activities towards Integrated and co-ordinated Programme Management (Charts)



Table/Graph 38 Centres involved in and the number of actions and people benefiting in relation to co-ordination in 2007

	Organisations	Events	People	OMUSATI	KHOMAS	OHANGWENA	OSHANA	KAVANGO	CAPRIVI	OSHIKOTO	OTJOZONDJUPA	ERONGO	KARAS	HARDAP	OMAHEKE	KUNENE
Developing HIV/AIDS management capacity	19	497	1,355	26	158	46	306	26	-	33	116	-	-	-	640	-
Management and Co-ordination	19	1,475	15,246	20	898	1,260	12,914	-	-	-	154	-	-	-	-	-
Programme monitoring and evaluation	71	1,253	11,091	1,286	281	992	1,200	-	-	116	666	-	-	23	50	25
Surveillance and operational research	6	11	40	-	18	-	-	-	-	-	-	-	-	-	-	-
People	**-**	**3,236**	**27,732**	**1,332**	**1,355**	**2,298**	**14,420**	**26**	**-**	**149**	**936**	**-**	**-**	**23**	**690**	**25**
Centres involved	**77**			**12**	**30**	**16**	**23**	**1**	**-**	**5**	**13**	**-**	**-**	**1**	**4**	**2**

Table/Graph 39 Centres involved in and the number of actions and people benefiting in relation to co-ordination in 2006

	Organisations	Events	People	OMUSATI	KHOMAS	OHANGWENA	OSHANA	KAVANGO	CAPRIVI	OSHIKOTO	OTJOZONDJUPA	ERONGO	KARAS	HARDAP	OMAHEKE	KUNENE
Developing HIV/AIDS management capacity	6	11	128	-	20	-	-	-	-	-	100	-	-	-	-	-
Management and Co-ordination	4	17	35	-	-	-	-	-	-	-	35	-	-	-	-	-
Programme monitoring and evaluation	8	29	1,790	-	100	-	-	-	-	-	-	1,500	41	60	-	-
Surveillance and operational research	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
People	**-**	**57**	**1,953**	**-**	**120**	**-**	**-**	**-**	**-**	**-**	**135**	**1,500**	**41**	**60**	**-**	**-**
Centres involved	**11**			**-**	**2**	**-**	**-**	**-**	**-**	**-**	**3**	**1**	**1**	**3**	**-**	**-**

3.8 Summary data

A complete summary of the collected data is shown in the following table:

Table/Graph 40 Summary data for all activity areas

MTP III Field	Activity	Centres	Actions	People benefiting	OMUSATI	KHOMAS	OHANGWENA	OSHANA	KAVANGO	CAPRIVI	OSHIKOTO	OTJOZONDJUPA	ERONGO	KARAS	HARDAP	OMAHEKE	KUNENE
1a	Sustained leadership commitment	76	652	13,424	80	589	55		7,220	3,322	16	104	575	184	76	652	13,424
1b	Greater involvement of PLWHA	71	869	18,675	320	202			6,097	1,740	95	233	825	256	71	869	18,675
1c	National policy development & law reform	13	135	2,512		1,436				100		59			13	135	2,512
1d	Sectoral & institutional policy development & reform																
1e	Social mobilisation to combat discrimination	28	202	16,341	1,248	1,617	1,000	1,000	1,850	1,550	1,600	1,121	1,000	1,000	28	202	16,341
1f	Actions to reduce stigma & discrimination	63	3,840	47,417	93	1,580	93	48	29,119	2,024	116	165	383	202	63	3,840	47,417
1g	Other	5	50	89		89									5	50	89
2a	Strengthen capacity to deliver prevention programmes	76	6,239	80,805	370	5,484	151	34	31,215	33,111	79	1,128	4,200	4,274	76	6,239	80,805
2b	BCI programmes for vulnerable populations	48	6,076	50,379	422	6,756			39,031	1,667	200	788	140		48	6,076	50,379
2c	BCI programmes for young people	79	6,845	74,275	2,845	11,863	55	65	32,543	4,723		972	13,607	1,306	79	6,845	74,275
2d	BCIs in schools	70	4,294	60,052	1,876	282	2,723	6,737	31,12	5,358		1,137	1,180	252	70	4,294	60,052

MTP III Field	Activity	Centres	Actions	People benefiting	OMUSATI	KHOMAS	OHANGWENA	OSHANA	KAVANGO	CAPRIVI	OSHIKOTO	OTJOZONDJUPA	ERONGO	KARAS	HARDAP	OMAHEKE	KUNENE
									0								
2e	Social mobilisation & awareness	83	178,959	286,450	81,382	2,755	2,689	96,447	92,999	3,445	43	2,736	3,024		83	178,959	286,450
2f	Workplace programmes	19	85	2,944	242	813			455	130	60	90			19	85	2,944
2g	Expand condom provision	73	155,533	206,139	14,611	3,740	17,372	28,427	57,477	4,960	951	16,408		20,000	73	155,533	206,139
2h	Strengthen STI management	9	127	4,124		2,789				250		20			9	127	4,124
2i	VCT	39	11,971	18,901	866	3,223	1,541	1,792	1,469	1,056	3,298	470	812	203	39	11,971	18,901
2j	Addressing vulnerability based on gender, violence & alcohol abuse	23	288	11,867	2,000	7,792	200	350		473		300			23	288	11,867
2k	Other	1	10	450	45	45	45		45		45	45	45	45	1	10	450
3a	Capacity development for expanded treatment care & support	9	205	6,652											9	205	6,652
3b	Collaborative TB/HIV/AIDS services	9	172	1,369	188	140	828					213			9	172	1,369
3c	Home based care	74	14,317	39,949	1,075	18,998	3,794	8,639	2,127	1,201	42	280	165	709	74	14,317	39,949
3d	Other	6	330	7,009									45		6	330	7,009
4a	Establish, strengthen & support communities and their response	19	196	2,874	171	216	207	1	360	750		171			19	196	2,874
4b	Develop capacity of local support groups of PLWHA & their	22	435	2,918	26	770		221	892	683	1	215			22	435	2,918

MTP III Field	Activity	Centres	Actions	People benefiting	OMUSATI	KHOMAS	OHANGWENA	OSHANA	KAVANGO	CAPRIVI	OSHIKOTO	OTJOZONDJUPA	ERONGO	KARAS	HARDAP	OMAHEKE	KUNENE
	families																
4c	Comprehensive services for OVC, carers & PLWHA	81	4,599	48,555	233	6,964	2,552	2,594	17,571	3,864	34	398	2,260	2,095	81	4,599	48,555
4d	Addressing poverty, food security, nutrition & housing	55	637	102,224		54,184	13,128	278	21,967	3,828	9	546	1,138	469	55	637	102,224
4e	Other	2	4	640	340										2	4	640
5a	Developing HIV/AIDS management capacity	19	497	1,355	26	158	46	306	26		33	116			19	497	1,355
5b	Management &Co-ordination	19	1,475	15,246	20	898	1,260	12,914				154			19	1,475	15,246
5c	Programme monitoring and evaluation	71	1,253	11,091	1,286	281	992	1,200			116	666			71	1,253	11,091
5d	Surveillance & operational research	6	11	40		18									6	11	40
5e	Other																
	Totals[18]	212	400,306	1,134,766	109,765	133,682	48,731	161,053	373,583	74,235	6,738	28,535	29,399	30,995	212	400,306	1,134,766

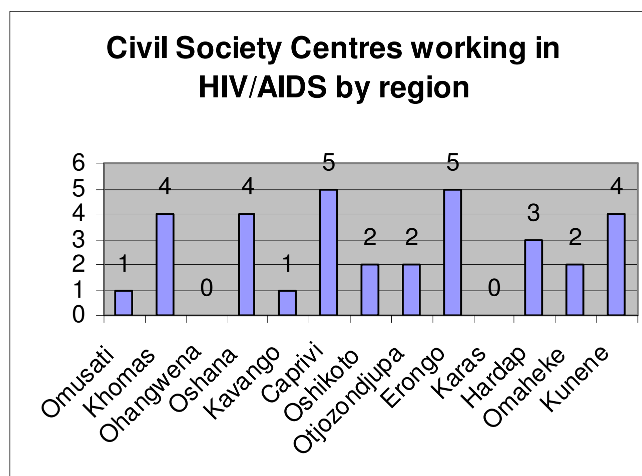
[18] Care should be taken with the totals, as there will have been double counting – for example, a person attending a drama event may also receive condoms

4 Trends

While the data collected from 2005, 2006 and 2007 has been presented in the graphs and tables of this report, it is not strictly possible to make comparisons between the data because the centres within the survey has changed from year to year. Changes might arise between one year and another because different organisations are reporting, rather than because actual activities have changed. Thus, where comparisons have been drawn in the previous Chapter, they were made on the basis of observing trends of scale and proportion, rather than examining strict statistical trends between one year and another.

32 centres contributed to the survey in 2005, 2006 and 2007 and this is just large enough a sample to use to consider trends over the three years at a national level. The centres were spread quite widely across Namibia, although there was no centre from Ohangwena or Karas.

Table/Graph 41 Regional coverage of the 32 centres replying in 2005, 2006 and 2007



20 of the centres are NGOs, 8 are CBOs and 4 are FBOs; together the centres represent 23 organisations.

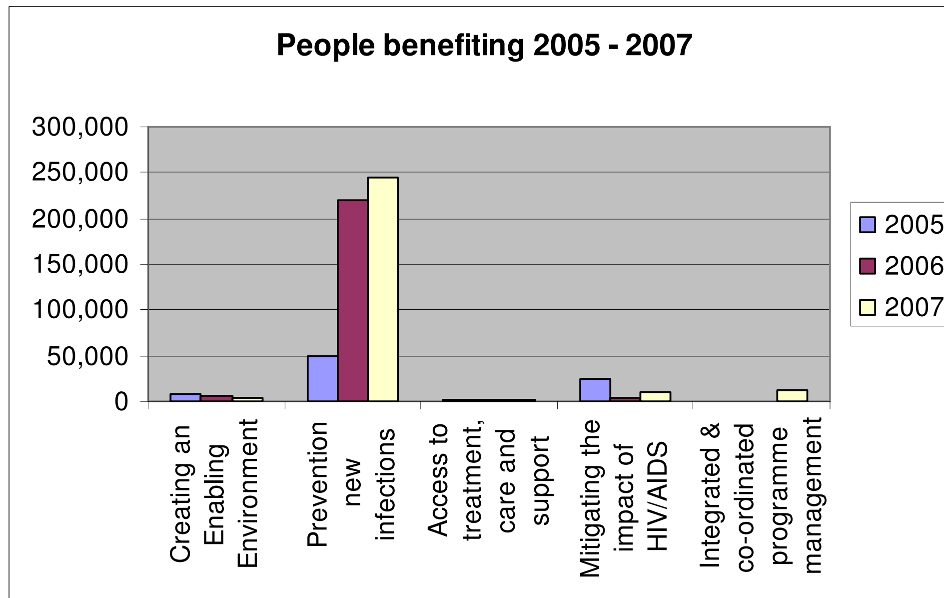
Looking firstly at staff and volunteer levels over the three years, one organisation - Development Aid from People to People - Total Control of the Epidemic (DAPP-TCE) – received substantial streams of new funding in 2006, with staff numbers rising from 40 to 558 and volunteers rising from 250 to 4,257. If the effect of this one organisation is stripped out, then overall staffing fell slightly in 2006 but rose again in 2007, while the number of volunteers rose slightly between 2005 and 2006, with numbers more or less sustained in 2007.

Table/Graph 42 Survey centre staff and volunteers 2005 - 2007

	Number of organisations			Number of staff (full-time and part-time)			Number of volunteers		
	2005	**2006**	**2007**	**2005**	**2006**	**2007**	**2005**	**2006**	**2007**
0 full-time staff recorded	15	13	14	5	1	0	293	198	231
1-9 staff	14	16	13	61	54	139	227	271	218
10-19 staff	3	2	4	46	26	55	1,000	1,000	1007
20+ staff	3	2	1	88	597	558	258	4,287	4,275
Totals	**35**	**35**	**32**	**194**	**678**	**752**	**1,778**	**5,756**	**5,731**

The number of centres with an e-mail address rose from 18 (55%) in 2005 to 21 (64%) in 2006 and remained at that level in 2007.

Table/Graph 43 Bar chart of people benefiting 2005, 2006 and 2007



The number of people affected by the 32 organisations over the 3 years was dominated the substantial increase in funding for DAPP-TCE with substantial increases in the numbers of people benefiting from programmes to prevent new infections. The numbers benefiting from the DAPP programmes alone in 2006 rose from 655 to 155,167. That increase was sustained in 2007, dominating the trends graph.

However, by considering the Table below, it may be observed that the numbers reported as benefiting from programmes aimed at Creating an Enabling Environment have steadily fallen (down by 2/3rds over the period, probably as a result of the fact that ASOs have moved from consultation on programmes to implementation); programme numbers relating to Access to treatment, care and support fell in 2006 but recovered in 2007; and a similar pattern may be observed in relation to Mitigating the impact of HIV/AIDS, although the overall numbers have not recovered to the 2005 levels. In relation to the numbers reported as benefitting from Integrated & co-ordinated programme management, the numbers are dominated by an activity affecting 12,000 people carried out by Yatala Youth Project; if this is discounted, the trend in this area is slightly upwards.

Table/Graph 44 Number of people benefiting from the 32 centres 2005 - 2007

Activity area	Number of people benefiting in total		
	2005	**2006**	**2007**
Creating an Enabling Environment	9,093	6,170	3,330
Prevention new infections	48,297	220,274	245,064
Access to treatment, care and support	2,258	1,403	2,075
Mitigating the impact of HIV/AIDS	24,934	4,464	10,811
Integrated & co-ordinated programme management	687	200	13,023
Totals	**87,274**	**234,517**	**274,303**

A more general comment on these trends from the M&E data collection teams is that changes in leadership have an impact on the numbers of activities. Smaller organisations in particular depend heavily on their leadership and as these leaders move to other organisations or locations the impact on the particular organisation can be very great.

The general fall in activities from 2005 to 2006 was considered from the perspective of the number of organisations reporting activity in each MTP III sub-heading is considered. In total, there are 32 MTP III sub-headings in which civil society is engaged.

Table/Graph 45 Activity falls and rises recorded between 2005 and 2006

Organisation active in the sub-heading		Activities reported		People affected	
MTP III sub headings recording a fall	21	MTP III sub headings recording a fall	20	MTP III sub headings recording a fall	19
MTP III sub headings recording a rise	5	MTP III sub headings recording a rise	10	MTP III sub headings recording a rise	9

What the above table seemed to indicate was a shift between 2005 and 2006, with fewer organisations being engaged in MTP III activities, although those who remain active are reporting rising activity. It was also suggested that this was the result of funds being directed to fewer, larger organisations. This was considered to be of particular concern in relation to Mitigation of the affects of the epidemic, where no rise was recorded in any of the relevant MTP III sub-headings.

The same review was carried out in relation to the 2007 activities, using 2005 as the baseline. No changes were recorded in relation to the activity headings as reported between 2005 and 2006. In other words, it appears that the relevant organisations have fallen into a pattern of activity, as influenced by the funding flows.

5 Conclusions

This is the third survey of civil society HIV/AIDS activity in Namibia. The survey is both a tool for monitoring activity within civil society and a tool for motivating organisations through a process which might be compared with mentoring. Because it is a process that has sought to achieve more outcomes than simple data gathering, with a range of support and mentoring objectives being included as part of the visiting process, there are some problems with the pure statistical basis of the survey and this report has sought to reflect these in the presentation of the data

Notwithstanding this, a number of conclusions may be drawn.

5.1 A significant contribution

In 2007, 212 Centres report some 400,000 actions or events over a 3 month period, covering 1,134,766 people. It is estimated from staff and volunteer records that this represents a 66% sample of the overall civil society activity. In 2005, the comparable figures were 107 centres recording nearly 10,000 events affecting nearly 200,000 people in the previous 3 months; it was estimated that the sample for 2005 covered around 60% of activities within Civil Society. In short, there appears to have been a sustained growth in civil society activities relating to HIV/AIDS, with activities and programmes reaching all parts of Namibia in significant volumes.

In 2007, around 310 organisations employ just over 2,000 full-time and part-time staff and have access to over 20,000 volunteers. In 2005, the M&E report estimated that nearly 250 organisations, employing just over 1,000 staff, with the support of over 15,000 volunteers were active in HIV/AIDS programmes. The figures for employment of staff and involvement of volunteers have not changed greatly between 2006 and 2007, although the numbers of organisations have risen by about 30 each year, suggesting a fragmentation of activity.

Altogether the figures suggest a huge national effort, the value of which cannot be underestimated. It means that in every part of the country there are individuals giving freely of their time and energy to tackle the epidemic.

Without it, the Namibian HIV/AIDS response would be immeasurably weaker.

5.2 The agencies involved

The 3 surveys together confirm the picture that 40-45% of the agencies involved in the HIV/AIDS effort have no full-time staff; together they have around 3,000 volunteers. 65-70% of all the agencies work in just one region.

At the other end of the scale, about half of the total effort, when measured by staff employed or volunteers engaged, is represented by some 10-12 organisations. These organisations in particular were strengthened by the arrival of the Global Funds programme in 2006.

There appears to be some in the numbers of part-time staff – rising from 283 in 2005 to 427 in 2007.

Large and small organisations offer different things. The large organisation can offer a management infrastructure that can deliver programmes on a large scale; they can also meet the accounting and reporting requirements of the larger donor agency. The small organisation can offer a specific, tailored local response that meets the needs of this or that community.

So it is necessary to offer a support framework that can take advantage of the resource, skills and commitment that all organisations can offer. This will need to be adaptable to the different scale that each organisation is working at. There is firm indication from the trends

over the three surveys that the support and delivery mechanisms are shifting in favour of the larger organisation.

While this shift can be understood, relating as it does to management mechanisms that wish to tackle the epidemic in a quick and direct way, mechanisms are also required to ensure that the major opportunity that is available through local efforts is maximised. There is clear evidence that a directive, top down approach to trying to solve the causes of the epidemic is not necessarily the most effective – particularly in relation to Behaviour change programmes. An enabling, supportive approach can ensure that communities address the cultural, attitudinal and behavioural issues that currently allow the epidemic to continue unabated.

5.3 Capacity building for CSO agencies

This report does not to argue that all of the agencies are as effective as the other. What central players need to do is to find ways of "picking the winners", nurturing these organisations to ever greater levels of effectiveness; but also to be able to respond to the small organisation and to value the fact that it is community based and will remain so. Central players need to adapt their approaches to the very varied picture of support being offered on the ground.

In addition, capacity building for agencies needs to be strengthened. The emerging NGO Management Qualification is aimed at strengthening capacity building efforts by making training competency based, career oriented and accredited to nationally agreed standards. Government and donors can support this by requiring that training efforts sponsored through them are linked to this national framework and by directly supporting the development of the Qualification.

Finally, it is disappointing to note that the NANASO sponsored service skills training at regional level in 2005 was not repeated in 2006 or 2007 because of a lack of funds. CSOs need to continue to develop their service skills and capacity; doing this at a regional level would enhance communication and engagement between agencies on the ground.

5.4 MTP III as a national framework

In 2005 many of the centres that NANASO visited had not heard of MTP III. In one sense this does not matter. Their work is the important issue and MTP III is merely a tool to bring this together into the national effort to tackle HIV/AIDS. From another perspective, it is valuable if people are much more aware of the national plan and their contribution to it. The research teams reported this in their feedback during their 2006 and 2007 visits – it was clear that organisations came to realise that their work is appreciated and that it fits into a national effort.

To achieve this requires as many agencies as possible to "think MTP III" and place their work in its context. In this way, MTP III will gain a more common recognition and will also be interpreted into terms useable at all levels.

Some Regional AIDS Coordinating Committees are clearly promoting this. Rather fewer Constituency AIDS Coordinating Committees are fully functional and are reflecting the framework of MTP III.

5.5 Prevention

In total, agencies were asked about their activities under 32 headings drawn from MTP III. When these activities are rank ordered according to the number of agencies active in each heading, 5 of the top 10 fields in both 2006 and 2007 are in the activity area of prevention activity. An even stronger statement of the emphasis on prevention is to be found when activities are ranked according to the numbers of people benefiting. The top 7 activity areas

in 2006 and 6 out of 7 of the top activity areas in 2007, when measured by the number of people who are recorded as benefiting, were Prevention activities, covering 86% (2007 67%) of all people claimed by respondents to benefit from their activities.

This focus of attention is driven by the funding flows, with around 50% of all resources for civil society being directed towards prevention.

Stopping the epidemic must be a top priority. However, this emphasis cannot be at the expense of other responses to the epidemic. The impact of HIV/AIDS and the need to deal with the consequences continues to grow. Orphans are increasing in numbers and need care. Poor people on ARV need solutions to the need for food and nutrition.

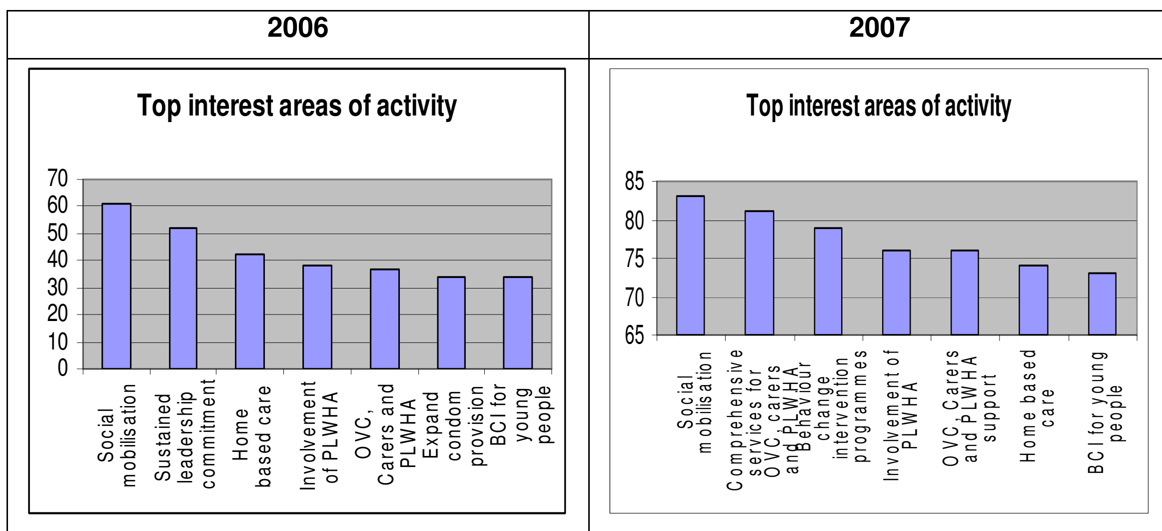
At the other end of the scale, people recorded as benefiting from workplace programmes represented only one tenth of 1% of the total number of people benefiting from interventions. It may be that employers are running workplace programmes within their companies with the help from agencies other than civil society agencies; but the issue needs to be examined in view of the national objective to ensure that workplace programmes ultimately cover 90% of large enterprises (including line ministries).

5.6 Orphans

Comprehensive services for OVC, carers and PLWHA are available across the country, although, as with other service areas, greater coordination of regional and local effort is desirable. The 2006 M&E survey indicated that funding for this work seems to be falling. The 2007 survey revealed substantial attempts by civil society organisations to tackle food security and provide income generating activities. Yet the Ministry of Gender and Child Welfare also announced in 2007 that only 46% of registered orphans are receiving benefits. In short, much more needs to be done in relation to Orphans and generally mitigating the impact of the epidemic.

5.7 Interest Areas

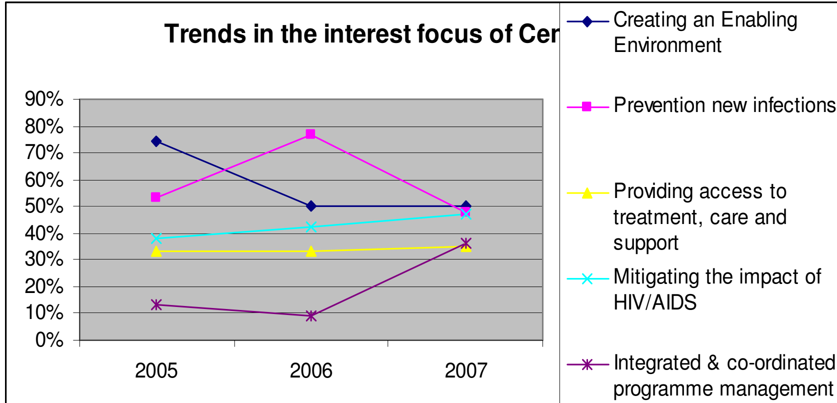
The strength of the effort from CSOs comes partly from the social awareness and motivation of the staff and volunteers on the ground. The



fullest national response will come from an effective dialogue between those who manage the resources available to tackle the epidemic and those on the ground. So the listings of which areas an organisation is involved in tells us where motivation of those on the ground lie, with (in 2006) Social mobilisation and awareness as the top activity area, followed by actions towards a Sustained leadership commitment. Importantly, the next top 3 areas are all

related to care and response to the epidemic and not to prevention activities – Home based care; Involvement of PLWHA; and Comprehensive services for OVC, carers and PLWHA. While the rank order changed slightly between 2006 and 2007, this focus on care, support and impact mitigation remains in 2007.

The chart of Trends in the interest focus of Centres over the three surveys brings out this growing interest.



So it is important that donors and HIV/AIDS programme managers consider both their view of the strategic priorities and the interest of volunteers and staff on the ground. A methodology that builds upon local responses will maximise the response on the ground – and will, undoubtedly, lead to more prevention activity, since engagement in mitigating the impact of the epidemic will draw people to define local prevention responses that are built upon local culture and attitudes but contain the changed behaviour that must underpin an effective response to the epidemic.

5.8 Coordination of local responses

While there appears to be improvement in relation to data collection at the constituency level, with data in 2006 and 2007 available for up to 68 constituencies (64% of all constituencies in Namibia) much better data at constituency level is needed in all service areas in order that targeting of resources can be improved and gaps in provision covered.

At a basic level, there is still inadequate networking between agencies on the ground. This is partly a response to the competition for funds.

But it is also to do with the funder strategies. This report argues for much a greater engagement with and encouragement of local responses – an enabling approach rather than a centrist approach. This calls for much greater mobilisation of local responses through the Constituency AIDS Committees (CACOCs), with resource allocations corresponding to the local responses that derive from this approach. To achieve this needs more resources for coordination at regional and local level – not on a large scale but sufficient to ensure that the CACOCs are functioning well. The result will be better local coordination and more effective use of resources. Additional spending on local coordination will lead to greater cost effectiveness.

5.9 Communications

How to keep people informed is a major issue in the more remote rural areas. It was clear from the survey that people were not necessarily using up to date information, or simply did not have information. As many different routes as possible for communication need to be developed, with a view to having every constituency locked into a national communication network.

Another aspect of this is getting appropriate IEC resources onto the ground. Materials that are available nationally are not there on the ground. As many materials in local languages need to be developed as possible.

This is not just a system problem. Field survey workers highlighted the energy of a member of the RACOC team who consistently made efforts to make sure that people on the ground received supplies. NANASO supplies brought as part of the visits were seized on. All can be active in reducing supply problems.

5.10 Engagement of PWLHA

In 2005, the M&E Report highlighted the fact that very few organisations were engaged in activities towards the greater involvement of PLWHA, with very little detail by way of activities or the region in which the activities took place.

The picture in 2006 changes sharply with many more organisations indicating activity in this field. The reasons for this are not clear but could well be linked to the availability of ARV treatment in all regions. Knowing one's status now has real meaning. But efforts have to continue to reduce the stigma associated with HIV/AIDS.

5.11 The role of external funders

The implications of the findings as to the wide range of sizes of service agencies is that support agencies need to provide a range of support services that is appropriate to the individual organisation's size. Not only do they need to be able to support well-established organisations with good infrastructure that is well used to dealing with formal structures; they need to ensure that they have mechanisms in place that make contact with the many small agencies that together appear to make up at least a quarter and up to a half of total activity by civil society. If they are not able to provide these mechanisms themselves, then they should link with organisations or structures that do make contact with the smaller agencies.

One of the features of the 2006 M&E report is how resources seem to be shifting to the larger organisations and how this reflects in changes in the activity areas. The survey teams reported on the other side of this picture – individual local initiatives that have stalled because funds have ceased to become available. The fact that no new funds were available through the Small Grants Fund in 2006 was a major loss to the smaller organisation.

NANASO and NANGOF are working with the other civil society umbrella agencies to strengthen the mechanisms in Namibia that channel funding support to the smaller organisation. Government and donor agencies are urged to support these efforts.

5.12 The role of Government

The leadership of government is paramount in tackling the epidemic. It is a role that the Government is clearly taking through the preparation and publication of MTP III through to the role and activity of the National Co-ordinating Programme (NACOP) based in the Ministry of Health and Social Services.

However, the scale of support available through civil society is substantial. The role of enabling is often far more difficult than the role of doing. But the opportunity to harness and shape such a huge resource as is potentially available is one that needs to be seized. Thus the enabling role has to be developed and the balance of the use of resources that are being made available to Namibia between government and civil society needs to be actively monitored to ensure a distribution that matches an overall view of activity.

The same need to monitor the application of resources applies to the government's own resources. There are certainly fields in which civil society is able to offer cost effective means of delivering national policy objectives, if they receive adequate financial support. One clear area is the role that civil society can play in relation to work with OVC. The failure to effectively come to terms with the issue of OVC is a major failure of the current response and

one in which the government could be far more effective if it worked in an enabling role with civil society.

5.13 Follow up

This report will be made available in as many ways as possible. The data is freely available from NANASO to any organisation that wishes to investigate particular themes further; the full benefit of the survey will come from all agencies reviewing and adapting their own work in the light of the data thrown up by the survey.

It is hoped that this series of annual surveys will continue. Data will improve as the techniques of the survey are improved and as respondents strengthen their support of the surveys through greater understanding and preparation. Time series data will show where gaps are being filled and activities are being or could be targeted better.

Nor should the value of the face to face contact with aids service organisations that was a bi-product of the survey be underestimated. Agencies are not on their own; and for those in more isolated communities, the survey proved a valuable reminder that they are not alone.

6 Appendix - Organisations providing data

Data has been recorded from 300 sites in the last 3 years. 35 of those sites were visited in each of the three years, marked by an asterisk. The organisations were:

	Organisation	Region	2005	2006	2007
	!NaraTraining Centre	Khomas			y
	Ada Khai Community Development Project	Oshikoto			y
	Ada Ma //Hao	Otjozondjupa			y
	Adolescent HIV Prevention Programme	Oshana	y		
	African Wild Dog Conservancy	Otjozondjupa	y		
*	Africare (Caprivi)	Caprivi	y	y	y
*	AIDS Care Trust	Khomas	y	y	y
	Aids Hero Action Group of Namibia	Oshana	y		
	Aids Total Care Centre	Khomas	y		y
	Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa - Namibia	Khomas			y
	Blouberg HIV/AIDS Committee	Omaheke			y
	Bukalo Support Group	Caprivi			y
	Caprivi College of Education HIV/AIDS Club	Caprivi			y
*	Caprivi Community Theatre Drama Group	Caprivi	y	y	y
*	Caprivi Hope For Life AIDS Awareness Group	Caprivi	y	y	y
	Caprivi Regional Youth Forum	Caprivi		y	
	Caprivi White Ribbon Forum	Caprivi			y
	Caprivi Youth Against Crime	Caprivi		y	y
*	Caprivi Youth Development Association	Caprivi	y	y	y
	Catholic AIDS Action	Khomas			y
	Catholic AIDS Action (Erongo)	Erongo	y		y
	Catholic AIDS Action (Hardap North)	Hardap	y		y
*	Catholic AIDS Action (Kalkrand)	Hardap	y	y	y
	Catholic AIDS Action (Karas)	Karas			y
	Catholic AIDS Action (Karasburg)	Karas			Y
	Catholic AIDS Action (Katima Mulilo)	Caprivi	y		Y
*	Catholic AIDS Action (Mariental)	Hardap	y	y	Y
	Catholic AIDS Action (Nyangana)	Kavango	y		Y
	Catholic AIDS Action (Omaheke)	Omaheke		y	Y
	Catholic AIDS Action (Omaruru)	Erongo		y	
	Catholic AIDS Action (Omusati-West)	Omusati			Y
	Catholic AIDS Action (Oshakati)	Oshana		y	
	Catholic AIDS Action (Otjimbingwe)	Erongo		y	y
	Catholic AIDS Action (Rundu)	Kavango			y
	Catholic AIDS Action (Spitzkoppe)	Erongo		y	
	Catholic AIDS Action (Usakos)	Erongo			y
	Catholic AIDS Action We Care-Gibeon	Hardap		y	y
	Change of Life Style	Khomas			y
*	Change of Life Styles (Erongo Regional Office)	Erongo	y	y	y
	Chief Zeraeua Traditional Authority	Erongo		y	
	Children Concerned	Kavango		y	
	Chobe Young Farmers Organisation	Caprivi		y	y

	Organisation	Region	2005	2006	2007
	Christina Swart Opperman Aids Orphans Foundation Trust	Khomas			y
	Church Alliance for Orphans	Khomas	y		y
*	Community Based Information Assistants	Caprivi	y	y	y
	Community Development Agency	Kavango		y	
	Community Outreach Theatre	Khomas	y		
	Community Unite for Development Organisation	Ohangwena	y		
	Criminals Return into Society	Khomas	y		y
*	Development Aid from People to People	Omusati	y	y	y
	DRC School Project, Community and New Start Centre	Erongo			y
	Dum Spiro Spero	Khomas		y	
	Eehana Multi-Media Centre	Ohangwena	y		
	Ehinga Rizepa Youth Organisation	Omaheke		y	
	ELCIN AIDS Action - Western Diocese	Oshana			y
	ELCIN AIDS Action (Eenhana)	Ohangwena		y	
	ELCIN AIDS Action (Engela)	Oshana	y		
	ELCIN AIDS Action (Rundu)	Kavango			y
	ELCIN AIDS Action -Eastern Diocese	Ohangwena			y
*	Endola HIV and AIDS Centre	Ohangwena	y	y	y
*	Endola Nappa Youth Club	Oshana	y	y	y
	Engela Parish Yakulafaneni Project	Ohangwena			y
	Erongo Disability Network	Erongo			y
*	Erongo Womens Network	Erongo	y	y	y
*	Evangelical Lutheran Church AIDS Programme	Hardap	y	y	y
	Evangelical Lutheran Church AIDS Programme (Gobabis)	Omaheke	y		y
	Evangelical Lutheran Church AIDS Programme (Hardap)	Hardap		y	y
	Evangelical Lutheran Church AIDS Programme (Omaheke)	Omaheke			y
	Evangelical Lutheran Church AIDS Programme (Otavi)	Otjozondjupa	y		y
	Evangelical Lutheran Church AIDS Programme (Otjimbingwe)	Erongo			y
	Evangelical Lutheran Church AIDS Programme (Otjiwarongo)	Otjozondjupa			y
	Evangelical Lutheran Church AIDS Programme (Outjo)	Kunene			y
	Evangelican Lutheran Church AIDS Programme (Noordoewer)	Karas	y		
	Evergreen Theatre Group	Omaheke			y
	Family Health International	Khomas			y
*	Freddy Khairabeb Community Centre	Erongo	y	y	y
*	Grace and Love Action Group	Oshikoto	y	y	y
	Grunau HIV/AIDS Committee	Karas			y
	Health Promotion Namibia Life Skills	Oshana			y
	Health Unlimited UK (Gobabis)	Omaheke	y		y
	Home Based Family Care Mothers Voice	Karas			y
	Hope AIDS Group	Khomas			y
	Hope House Refuge for Kids (Teenagers)	Erongo		y	
	Hosianna Assistance and Orphans Care Group	Erongo			y
	Human Development and Care	Khomas		y	
	Ibis - Nothern Support Office	Oshana		y	
	Ikondjela Mwene Support Group	Omusati			y
	Ileni Tulikwafeni	Otjozondjupa	y		y
	Imangulula	Omusati			y
	Imangulula Clara Support Group	Omusati			y
	Indileni Homebased Care Elondo	Omusati			y
	Information and Support Centre	Kavango			y

	Organisation	Region	2005	2006	2007
	Institute of Clinical Biochemistry	Khomas			y
	IRDNC	Caprivi			y
	Ivanna lafigliola-Kriner/DRC School Project	Erongo	y		
*	Jabez Obedien Youth Centre	Otjozondjupa	y	y	y
	Johanniter Hilfswerk	Khomas			y
	Joint Compassion Keepers - (Love for a Child)	Erongo			y
	Joint Consultative Council	Khomas			y
*	Jonah Home for Children	Erongo	y	y	y
	Kalunga Tukwafa	Ohangwena			y
	Kaoko - Epupa Development Foundation	Kunene		y	
	Kaoko Development League	Kunene		y	
	Kapukuru Drama Group	Kavango		y	
	Karasburg Communty Organisation for Social Development and Care	Karas			y
	Kasheshe Support Group	Caprivi			y
*	Kasoyetua AIDS Committee (Omaheke)	Omaheke	y	y	y
	Kasoyetua Youth Group of Namibia (Okondjatu)	Otjozondjupa	y		
	Katonyala	Oshikoto	y		y
	Kavango Action For Youth Development	Kavango		y	y
	Kavango Bridges of Hope	Kavango			y
	Kavango Community Consultancy	Kavango		y	
	Kavango Voluntary Community Support Organisation	Kavango		y	y
	Kavango Youth Positive Living Ambassador	Kavango		y	
*	Khomas Women in Development	Khomas	y	y	y
	Khorixas Youth Against Crime HIV/AIDS Programme	Kunene	y		
	Kovambo Against AIDS	Omusati			y
	Kuisebmond Community Centre	Erongo			y
	Kuku Kovambo Nujoma Orphans and Vulnerable Children Trust	Omusati			y
	Kunamutanda Youth Club	Kunene			y
	Legal Assistance Centre	Khomas			y
	Life Fighters (ELCAP Okahandja)	Otjozondjupa	y		
	Lifeline/Childline (Eenhana Regional Office)	Ohangwena		y	y
	Lifeline/Childline (Kavango)	Kavango	y		y
	Lifeline/Childline (North-Central)	Oshana			y
	Lifeline/Childline (North-West)			y	
	Lifeline/Childline Namibia	Khomas	y		y
	Light for Children (Gospel Trust) Gobabis	Omaheke			y
	Likunga Project	Kavango		y	
	Lironga Eparu (Caprivi)	Caprivi	y		y
	Lironga Eparu (Endola)	Oshana	y		
*	Lironga Eparu (Kavango)	Kavango	y	y	y
*	Lironga Eparu (Khorixas)	Kunene	y	y	y
	Lironga Eparu (North Central)	Oshana			y
*	Lironga Eparu (Omaheke)	Omaheke	y	y	y
	Lironga Eparu (Oshikoto)	Oshikoto			y
	Liselo Support Group	Caprivi			y
	Lyanyanda Support Group	Caprivi			y
*	Ma/hao Womens Organisation	Kunene	y	y	y
	Macedonia HIV/AIDS Home Based Care Group	Khomas		y	
*	Medicos del Mundo	Erongo	y	y	

	Organisation	Region	2005	2006	2007
	Medicos del Mundo - Kunene	Kunene		y	
	Military Action Prevention Programme	Kavango			y
	Miracle Psychosocial and Spiritual Support House	Khomas	y		
	Mothers Voice	Khomas			y
	Mothers Voice (Keetmanshoop)	Karas		y	
	Multipurpose Help Centre	Otjozondjupa	y	y	
	Musanga Support Group	Caprivi			y
	Musinda Anti-AIDS Campaign	Kavango		y	
	Mutjima Gumwe	Kavango		y	
	Namibia Business Coalition on AIDS	Khomas			y
	Namibia Christian Apostles and Prophet Association	Khomas		y	
	Namibia Community Development Organisation	Khomas	y		
	Namibia Men Planned Parenthood Network	Erongo	y		y
	Namibia National Teachers Union	Khomas			y
	Namibia National Teachers Union (Kavango)	Kavango			y
	Namibia National Women Organisation - Kavango Region	Kavango		y	
	Namibia Planned Parenthood Association (Ohangwena Regional Office)	Ohangwena		y	y
	Namibia Planned Parenthood Association Youth Resource Centre	Hardap			y
	Namibia Red Cross Society (Eenhana)	Ohangwena			y
	Namibia Red Cross Society (Katima Mulilo)	Caprivi	y		
	Namibia Red Cross Society (Omaheke)	Omaheke			y
*	Namibia Red Cross Society (Opuwo)	Kunene	y	y	y
	Namibia Red Cross Society (Rundu)	Kavango	y		y
	Namibia Rural Development Project	Khomas		y	
	Namibia Shebeen Association	Khomas		y	
	Namibia Transport and Allied Workers Union	Khomas			y
*	Namibia Women's Network	Khomas	y	y	y
	Namibia Women's Network (Otjozondjupa)	Otjozondjupa			y
	Namibian Men for Change (Caprivi)	Caprivi			y
	Namibian National Association of The Deaf	Khomas			y
	Namibian National Association of The Deaf (Omusati)	Omusati			y
	Namibian National Teachers Union	Khomas		y	
	NANGOF Trust	Khomas			y
	National Council for Older Persons in Namibia	Khomas		y	
	National Federation of People with Disabilities in Namibia	Khomas			y
*	National Social Marketing Association	Khomas	y	y	y
	National Social Marketing Association (Keetmanshoop)	Karas		y	y
	National Social Marketing Association (Otjiwarongo)	Otjozondjupa	y		y
	National Social Marketing Association (Rundu)	Kavango	y		y
	National Union of Namibia Workers	Khomas			y
	National Youth Council of Namibia	Khomas			y
	Nawa Life Trust	Khomas			y
	NEDICO (Rundu) (Mapilelo Project)	Caprivi			y
	New Start VCT (Andara)	Kavango			y
	New Start VCT (CCN, Katutura)	Khomas			y
	New Start VCT (Eenhana)	Ohangwena		y	y
	New Start VCT (ELCAP, Mariental)	Hardap		y	y
	New Start VCT (ELCAP, Rehoboth)	Hardap	y		y
	New Start VCT (Katima Mulilo)	Caprivi	y		y

	Organisation	Region	2005	2006	2007
	New Start VCT (Keetmanshoop)	Karas			y
	New Start VCT (Nyangana)	Kavango			y
	New Start VCT (Oshikango)	Ohangwena		y	y
	New Start VCT (Oshikuku)	Omusati	y		y
	New Start VCT (Otjiwarongo)	Otjozondjupa		y	y
	New Start VCT (Outapi)	Omusati		y	y
	New Start VCT (Rundu)	Kavango	y		y
	New Start VCT (Swakopmund)	Erongo		y	
	New Start VCT (Tonateni, Oshakati)	Oshana		y	y
*	New Start VCT (Walvis Bay)	Erongo	y	y	y
	Ngaturuise Ehinga Youth Organisation	Khomas		y	
	Ohangwena Youth Drama Group	Ohangwena	y		y
	Okahandja Home Based Caregiver	Otjozondjupa			y
	Okahandja Samaritans Network	Otjozondjupa	y		y
	Okakarara Home Based Care Givers	Otjozondjupa	y		y
	Okarindi Kozonguvi Youth Club	Khomas			y
	Okathitu Anglican Home Based Care Lazarus Centre	Omusati	y		y
	Okatumbatumba Hawkers Association	Khomas	y		
	Okombahe District AIDS Committee	Kunene		y	
	Omaheke Gospel Trust	Omaheke	y		
	Omaheke Health Education Programme	Omaheke		y	
	Omaheke Rural Youth HIV/AIDS Campaign	Omaheke	y		
	Omaheke San Trust	Omaheke		y	
	Ombetja Yehinga Organisation	Khomas		y	y
	Ombetja Yehinga Organisation (Erongo)	Erongo	y		
	Ombetja Yehinga Organisation (Khorixas)	Kunene			y
*	Ombetja Yehinga Organisation (Opuwo)	Kunene	y	y	y
	Ombome Oto Homebased Care Project	Ohangwena	y		y
	Omitara Health Committee	Omaheke			y
	Omwene Anglican Tumenge Home Based Care	Ohangwena	y		y
	Omwene Tukwafa	Oshana	y		
	Omwene Tutalulula Support Group	Ohangwena	y		
	Ondangwa HIV/AIDS Support Group	Oshana			y
	Ongendo Development Trust	Omaheke	y		y
	Ongwendiva Aids Care and Prevention Project	Oshana			y
	Ongwendiva Youth Club	Oshana			y
	Orphans & Vulnerable Children Pilot Project	Ohangwena			y
	Oshakati Multi Purpose Youth Centre	Oshana			y
	Oshana Youth Choir and Cultural Group	Oshana			y
	Oshandi Community Youth Educators	Ohangwena		y	y
	Otavi HIV/AIDS Support Group	Otjozondjupa	y		
	Otjinene Farmers Association	Omaheke	y		
	Otjiwarongo Arts Centre	Otjozondjupa		y	y
	Otjiwarongo HIV/AIDS Support Group	Otjozondjupa		y	
	Otjiwarongo Multipurpose Help Centre	Otjozondjupa			y
	Otjombinde Clinical Health Committee	Omaheke	y		
	Otjombinde Farmers Association	Omaheke	y		
	OTO - OTTA - Oshikango	Ohangwena			y
	Ozonahi Conservancy	Otjozondjupa			y
	Penduka Development Organisation	Khomas		y	

	Organisation	Region	2005	2006	2007
	People Health Project	Oshana			y
	People in Need	Karas			y
	Pioneer Youth With a Purpose	Khomas			y
	Polytechnic of Namibia	Khomas		y	y
	Positive but Confident (Tusano) Helping Hand	Erongo		y	
	Project HOPE Nambia	Khomas		y	
	Rundu College of Education	Kavango			y
	Rundu Vocational Training Centre	Kavango			y
	Runone Support Group	Kavango		y	
	Rural Youth HIV/AIDS/TB Campaign	Omaheke	y		
	Sam Nujoma Multi-Purpose Centre	Oshana			y
	Scripture Union Namibia	Khomas			y
	Shalom Mabasen Aids Group(Elcap Branch)	Erongo			y
	Sibinda Support Group	Caprivi			y
	Sigo Aluhe Support Group	Omusati			y
	Simons Club of AIDS Awareness	Omusati			y
	Sister Namibia	Khomas			y
	Social Marketing Association	Khomas		y	
	Social Marketing Association (Caprivi)	Caprivi	y		
	Social Marketing Association (Kavango)	Kavango	y		y
	SOS Children's Village	Oshikoto			y
	St John Apostolic Holiness Church of Africa	Khomas		y	
	St Leoni's Care Centre	Oshikoto			y
	St Petrus Home Care Centre	Erongo		y	
	Step by Step HIV/AIDS Project	Khomas			y
	Swakopmund Counselling Centre	Erongo	y		
	Tanibagu HIV/AIDS Support Group	Oshikoto	y	y	
	The ARK Rehoboth - Christ's Hope Namibia	Hardap	y		
	The House of Love for OVC	Kavango			y
	TKMOAMS	Oshana	y		y
*	TOV Multipurpose Centre	Oshikoto	y	y	y
	Trans Kalahari Border Post HIV/AIDS Committee	Omaheke	y		
	True Love Waits	Khomas			y
	True Love Waits - Walvis Bay	Erongo		y	y
	Tukwathela Support Group	Oshana			y
	Tupoperenu Youth Group	Kavango		y	
	Tupopila Support Group	Oshana			y
	Tusano Support Group	Kavango			y
	Tuzeni Komeho Anti-HIV/AIDS	Oshana		y	
	Two Hands Home Based Care Unit	Karas	y		y
	UBIB - Morester	Karas			y
	Ulilifa Iho li kanifa	Oshana		y	
	United Methodist Youth Action	Kavango		y	y
	Uzuni Kapiru Community Action Forum	Kavango		y	
	Village Health Care Project	Oshana	y		
	Walvis Bay Multi - Purpose Centre Trust	Erongo	y		y
	We are doing it at God's Grace	Otjozondjupa	y		
	Welfare Mission for Old Age People	Erongo		y	y
	White Ribbon Campaign Namibia	Khomas		y	
	White Ribbon Campaign Namibia (Katima Mulilo)	Caprivi		y	

	Organisation	Region	2005	2006	2007
	Women and AIDS Support Network	Khomas		y	
	Women's Action for Development (Otjinene)	Omaheke	y		
*	Yatala Youth Project	Oshana	y	y	y
	Yelula Project	Oshana		y	
	Young Womens Christian Association of Namibia	Khomas	y		y
*	Youth 2000 Theatre Group	Oshana	y	y	y
	Youth for Christ -Rundu	Kavango		y	y
	Youth Health Development Programme	Khomas		y	y
	Youth to Youth Namibia	Kavango		y	y
	Zambezi Vocational Training Centre	Caprivi	y		y

7 Appendix - Detailed working table showing likely HIV/AIDS incidence by region

Region	# of pop. 2001	growth rate per region	2002	2003	2004	2005	HIV prev 2004 %	# of PLHWA for 15 - 59 years with pop increase	# of PLWHA with AIDS
Omusati	228,842	1.5	232,275	235,759	239,295	242,885	21	26,676	4,001
Khomas	250,262	4.0	260,272	270,683	281,511	292,771	17	26,030	3,905
Ohangwena	228,384	2.4	233,865	239,478	245,225	251,111	18	23,640	3,546
Oshana	161,916	1.8	164,830	167,797	170,818	173,893	25	22,736	3,410
Kavango	202,694	3.7	210,194	217,971	226,036	234,399	18	22,066	3,310
Caprivi	79,826	1.8	81,263	82,726	84,215	85,731	43	19,280	2,892
Oshikoto	161,007	2.2	164,549	168,169	171,869	175,650	20	18,373	2,756
Otjozondjupa	135,384	2.8	139,175	143,072	147,078	151,196	23	18,187	2,728
Erongo	107,663	1.3	109,063	110,480	111,917	113,372	27	16,009	2,401
Karas	69,329	1.3	70,230	71,143	72,068	73,005	19	7,255	1,088
Hardap	68,249	0.3	68,454	68,659	68,865	69,072	15	5,419	813
Omaheke	68,039	2.5	69,740	71,483	73,271	75,102	14	5,499	825
Kunene	68,735	1.9	70,041	71,372	72,728	74,110	10	3,876	581
NAMIBIA	**1,830,330**		**1,873,951**	**1,918,793**	**1,964,894**	**2,012,295**	**19.80%**	**215,046**	**32,257**

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