



HIV/AIDS HEALTH PROFILE

| HIV and AIDS Estimates | |
|------------------------------------------------------------------------------|--------------------------------------|
| Total Population* | 2.2 million (mid-2010) |
| Estimated Population Living with HIV/AIDS** | 200,000 (160,000–230,000) (end 2007) |
| Adult HIV Prevalence** | 15.3% (12.4–18.1%) (end 2007) |
| HIV Prevalence in Most-at-Risk Populations** | MSM: 12.4% (end 2007) |
| Percentage of HIV-Infected People Receiving Antiretroviral Therapy*** | >95% (2009) |

* Population Reference Bureau 2010 **UNAIDS ***WHO/UNAIDS/UNICEF *Towards Universal Access* 2010

The first HIV infection in Namibia was diagnosed in 1986, and the country now faces a mature generalized HIV epidemic that is primarily sexually transmitted. Antenatal clinic (ANC) surveillance data show HIV prevalence rates among women increased to a high of 22 percent in 2002, leveled off at 20 percent in 2004 and 2006, and dropped to 18 percent in 2008, according to the 2008 National HIV Sentinel Survey. While the Joint United Nations Program on HIV/AIDS (UNAIDS) reported 15.3 percent prevalence in 2007, there is now evidence of a decline in prevalence to an interim 2009 Spectrum model estimate of 13.3 percent for 2008–2009. Namibia remains among the eight countries with the highest prevalence rates in the world, according to the

Population Reference Bureau, requiring continued attention to both treatment and prevention. The population of 2.2 million is highly dispersed, creating challenges in accessing services and reaching remote populations. HIV prevalence varies greatly by region, from 6 percent to more than 30 percent; it is higher in the more densely populated regions along the northern borders with Angola, Botswana, and Zambia (Ministry of Health and Social Services [MoHSS] Report of the 2008 National HIV Sentinel Survey).

Key drivers of the epidemic include multiple and concurrent partnerships, decline in marital or cohabiting relationships, inconsistent condom use (especially among married couples), excessive alcohol use, intergenerational sex, transactional sex, lack of male circumcision, and a low proportion of the population that knows its HIV status (MoHSS, 2008). Additional drivers include high levels of population mobility, poverty, gender inequality, and gender-based violence. More than 5,800 people were estimated to be newly infected with HIV in 2008–2009, which amounts to about 16 infections per day, according to the 2010 United Nations General Assembly Special Session (UNGASS) report. It is estimated that one-fourth of these new infections were among infants; just over one-third (31 percent) were among those 15 to 24 years of age, and more than one-third (37 percent) were among persons aged 25 or older (National Strategic Framework, 2010).

While prevalence among older demographic groups (30 to 34 years of age) has increased, prevalence among younger women (15 to 19 years of age) attending ANC facilities has declined from 12 percent in 2000 to 5 percent in 2008. This trend is consistent with a mature epidemic in which there are fewer new infections (MoHSS, 2010). Three contributing factors may account for this welcome decline in HIV. The first is a reduction in risk behaviors, which has led to fewer new infections. A comparison between the Namibia Demographic and Health Survey (NDHS) for 2000 and the NDHS for 2006 indicated such a reduction has occurred. The second is pool saturation, where those most likely to be infected have already been infected. The third is Namibia’s high antiretroviral therapy (ART) coverage (87 percent, according to the World Health Organization [WHO]). ART reduces viral load and thus infectivity (Measure MoHSS, 2009).

Nongovernmental organizations (NGOs), faith-based organizations (FBOs), and other private organizations are the primary providers of outreach to most-at-risk populations (MARPs), including sex workers, injecting drug users (IDUs), and men who have sex with men (MSM). Other high-risk populations include transport workers, out-of-school youth, fishermen, and mobile workers. Programs for sex workers often target those in the capital city of Windhoek, the seaport city of Walvis Bay, as well as Oshikango border, although there is a strong need for programs in other cities and in rural areas.

Data on the size and behaviors of MARPs in Namibia are limited. One independent study found a prevalence of 12.4 percent among MSM in Namibia, but its sample size (218 participants) was small. HIV prevalence among MSM over 30 years of age was double the rate across all men surveyed. Lack of consistent condom use and



improper condom use among MSM were identified as two driving factors behind the higher prevalence rate for the MSM subpopulation (Baral et al., 2009).

Multiple concurrent partnerships, coupled with low condom use, are of great concern due to the high prevalence of HIV in the general population. The percentage of adults who had more than one sexual partner in the past year and who reported the use of a condom at their last sexual encounter is higher among men (74.4 percent) than women (65.7 percent), according to the 2006 NDHS. The proportion of men and women who have been tested in the last year and know their status is low, at 17.6 percent and 28.6 percent, respectively (NDHS, 2006). Voluntary counseling and testing is available in virtually all (98 percent) of Namibia's 411 health facilities, according to the 2009 National Health Facility Census (NHFC).

With 96 percent of pregnant women accessing ANC at least once prior to delivery, Namibia has the potential to eliminate most, if not all, maternal transmission of HIV (UNGASS, 2010). Since prevention of mother-to-child transmission of HIV (PMTCT) services were first introduced in 2002, the number of women receiving them has grown. PMTCT coverage for HIV-positive women has increased from 25 percent in 2005 to 58 percent in 2009, while the estimated percentage of all HIV-infected infants born to HIV-infected mothers has dropped from 28 percent in 2005 to 12.7 percent in 2009 (UNGASS, 2010). More than one half of Namibia's 306 facilities that provide ANC currently offer the minimum PMTCT package, according to the 2009 NHFC. At the same time, the World Health Organization (WHO) estimates 53 percent of deaths among children under 5 years of age can be attributed to HIV, and 45 percent of orphaned children have lost one or both parents to AIDS.

Tuberculosis (TB) is a major health problem in the country, particularly for PLWHA. According to WHO, the TB incidence rate in Namibia was 750 cases per 100,000 population in 2008, and approximately 59 percent of adults with TB are HIV positive, complicating the care and treatment of both diseases.

National Response

Namibia's long-term planning framework, Vision 2030, regards HIV as one of the most serious threats facing the country and highlights the need to mainstream HIV programs to meet the country's development challenges. The government has worked to develop an integrated approach to combating HIV, engaging individuals and agencies across all sectors, as well as civil society and people living with HIV/AIDS (PLWHA) themselves.

The first HIV/AIDS strategic plan was launched in 1992 with the implementation of a Short Term Plan, which established the National AIDS Control Program; it was housed within the MoHSS. In March 1999, the Government launched the Second National Strategic Plan for HIV/AIDS (Medium Term Plan II, 1999–2004), replacing the National AIDS Control Program with the National AIDS Coordination Program. The Medium Term Plan II strengthened support for HIV/AIDS prevention and control efforts, and focused on mobilizing all partners to reduce HIV incidence. It also addressed stigma and discrimination and access to quality health services for PLWHA. The response to the epidemic was then guided by the Third National Strategic Plan for HIV/AIDS (Medium Term Plan III, 2004–2009), which emphasized prevention of the spread of HIV, primarily through behavior change and stigma reduction. It also facilitated improved access to antiretroviral drugs (ARVs) and ensured the mainstreaming of HIV programs in all sectors. The Plan brought together program implementers from government and private organizations, such as NGOs, FBOs, and community-based organizations, to streamline the response to the epidemic.

A new six-year National Strategic Framework (NSF) for HIV/AIDS is soon to be in place for 2010–2011 through 2015–2016. It has been approved by the nation's cabinet and is expected to be ratified by Parliament in the fall of 2010. The NSF articulates a strategic alignment of the national multisectoral HIV response to the other national socioeconomic development frameworks, such as Vision 2030, the National Development Plans, and the Poverty Reduction Strategy. The NSF is based on evidence, uses a results-based approach, and focuses on the gender and human rights aspects of HIV/AIDS in order to ensure they are addressed across the response to the epidemic.

Namibia has received international recognition for its success in rolling out ART services. As of March 2010, Namibia more than doubled its original 2009 target of reaching 25,000 HIV-infected persons by reaching 64,637 HIV-positive persons in need of ARVs. ART services are offered in 141 centers, including all 35 state hospitals (UNGASS, 2010). According to the 2010 WHO/UNAIDS/UNICEF *Towards Universal Access* report, more than 95

percent of people with advanced HIV were receiving ART, in accordance with the 2006 WHO guidelines. In its new 2010 guidelines, the WHO has shifted its recommendation on when to initiate ART. In the past, it recommended patients begin ART when their CD4 counts (the number of a specific type of white blood cells in a given sample) were below 200. The WHO now recommends patients initiate treatment when their CD4 counts are below 350. According to this new recommendation, a significantly higher number of individuals are in need of ART. Meeting this increased need will be a major challenge. More than 80 percent of PLWHA were covered by a facility providing ART, although the highly dispersed population makes accessing health care difficult for many rural Namibians. Home-based care has been effectively integrated into the rollout of ART.

The Government views the protection of the rights of PLWHA as a critical means of minimizing stigma and discrimination. Accordingly, it has made such protection a priority, as evident in the focus of the new strategic plan. Policies often focus on PLWHA, pregnant women, and young children but exclude MSM, IDUs, and sex workers. According to data from the 2006 NDHS, discrimination against PLWHA is diminishing, and the Government has taken specific policy measures to continue its downward trend. Moreover, workplace policies combating discrimination are becoming more common. In 2009, the Government committed to lifting the travel restriction for PLWHA; this restriction was lifted in July 2010.

Many challenges remain in protecting the rights of PLWHA, primarily in implementing and enforcing anti-discrimination policies. For example, there are only a limited number of programs for MARPs, including MSM, sex workers, and IDUs. This minimizes their ability to seek protection for the rights of MARPs under the law. An independent study found 42 percent of MSM had experienced at least one rights abuse, such as blackmail, denial of housing, or denial of health care. Treatment and support for MARPs has been identified in the 2010 UNGASS report as an area in need of improvement.

Private sector engagement strengthens the response to the HIV epidemic in Namibia. The Namibia Business Coalition on AIDS (NABCOA) is the recognized leader of the private sector response to the epidemic, and has engaged in multiple public-private partnerships (PPPs). In 2009, NABCOA initiated a joint PPP called *Bophelo!* This mobile wellness screening project led by NABCOA, PharmAccess (a Namibia-based foundation to improve access to quality HIV/AIDS and related health care), and the Namibia Institute of Pathology travels to worksites around the country with specially equipped vehicles, testing employees for a range of health indicators, including HIV status. The service is cost-shared with the participating employers. In 2010, NABCOA, PharmAccess, and Standard Bank Namibia also teamed up to lead a major private sector proposal to the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Due to Namibia's classification by the World Bank as an upper-middle-income country, donor support to the country is more limited than in other parts of sub-Saharan Africa. The German Development Corporation and the U.S. Government (USG) are the two primary bilateral donors; the country also relies on resources from the Global Fund to support HIV prevention, treatment, care, and support programs. The Global Fund approved a \$104 million, second-round grant to support an HIV program. The program supported by the grant aims to reduce the impact of HIV/AIDS through integrated prevention, treatment, care, and support programs, as well as reduce the impact of HIV on affected populations. The USG provides nearly 30 percent of the Global Fund's total contributions worldwide.

USAID Support

Through the U.S. Agency for International Development (USAID), Namibia received \$46.6 million in fiscal year (FY) 2009 for essential HIV/AIDS programs and services. USAID's HIV/AIDS programs in Namibia are implemented as part of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). Launched in 2003, PEPFAR is the USG initiative to support partner nations around the world in responding to HIV/AIDS. Through PEPFAR, the USG has committed approximately \$32 billion to bilateral HIV/AIDS programs and the Global Fund through FY 2010. PEPFAR is the cornerstone of the President's Global Health Initiative (GHI), which commits \$63 billion over six years to support partner countries in improving and expanding access to health services. Building on the successes of PEPFAR, GHI supports partner countries in improving health outcomes through strengthened health systems, with a particular focus on improving the health of women, newborns, and children.

Funding from USAID for FY 2009 included \$15.8 million for prevention, \$15.3 million for care, \$5.5 million for treatment, and \$9.8 million for other activities, including health systems strengthening for key Government of Namibia line Ministries (including the MoHSS and, for orphans and vulnerable children (OVC) programs, the Ministry of Gender Equality and Child Welfare) and Namibian NGO implementing partners. Through a diverse portfolio of 25 programs, USAID/Namibia works at the community, facility, and national levels. At the community level, projects implement prevention, care, and support services; at the national level, programs provide health

services and pharmacy services in public and faith-based hospitals and clinics; at the national level, projects work to improve national policies and programs in health, education, and social services.

Namibia exemplifies the positive results of partnerships tackling HIV/AIDS. In September 2010, the USG signed a five-year, \$100 million Partnership Framework (PF) with the Government of Namibia to promote sustainable national ownership and leadership of HIV/AIDS programs. The PF will extend PEPFAR support to focus on sustainability, health systems' strengthening, and capacity development in the national HIV/AIDS response to improve Namibia's health and health care. The country has been home to multiple PEPFAR initiatives, and declines in prevalence among youth (15 to 24 years old) are encouraging. Innovative programs have included Prevention with Persons Living with HIV, providing PLWHA with information about how to protect themselves and their partners, early diagnosis for infants, and cervical cancer screening for women. New and scaled-up programs for 2009 focused on promoting male circumcision; the role of alcohol abuse in HIV transmission and treatment adherence; integrating prevention into schools, the military, and home-based care programs; and addressing risk factors contributing to cross-generational and transactional sex. PMTCT, which uses an opt-out testing strategy, continues to be a priority, as well.

The top priority for USG programs is to increase staff capacity within the public health services to ensure Namibia has the human resources necessary to continue to fight HIV/AIDS. In 2009, PEPFAR support focused on treatment activities that decentralized services, improved quality, supported procurement and supply chain management of ARVs, expanded coverage to more rural sites, built human capacity, and delivered quality treatment and prevention services.

Major PEPFAR program achievements of FY 2009 included:

- 70,600 individuals receiving ART
- 30,800 pregnant women receiving PMTCT services, including 5,000 who were receiving ART
- 231,200 receiving counseling and testing
- 518,100 individuals reached with community outreach HIV/AIDS prevention activities that promote correct and consistent use of condoms and related interventions

The response to the HIV/AIDS epidemic in Namibia is also supported by the USAID Southern Africa Regional HIV/AIDS Program. Through the Regional Program, the Bureau for Africa uses its resources to strengthen USAID Missions in Africa, build the capacities of African partner institutions, and promote activities that guide partners' capabilities to fight the epidemic and mitigate its effect. In 2008, national business coalitions and other stakeholders in Namibia were trained in HIV-related institutional capacity building. The training-of-trainers format for the combined HIV/AIDS prevention, business management, and legal training will enable attendees to reach out to small- and medium-sized enterprises on which many HIV-positive individuals depend. The Namibian Government also partnered with the USG to improve chronic skills shortages and the delivery of crucial HIV-related services. In 2009, home-based care programs adapted OVC tools and processes to establish standards of care and improve programming.

Important Links and Contacts

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Web site: <http://www.usaid.gov/missions/>

USAID's HIV/AIDS Web site for Namibia: <http://namibia.usaid.gov>.

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USAID's HIV/AIDS Web site for Southern Africa:

http://www.usaid.gov/our_work/global_health/aids/Countries/africa/saregional.html.

For more information, see USAID's HIV/AIDS Web site: http://www.usaid.gov/our_work/global_health/aids.

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