

NAMIBIA FINAL REPORT

September 2000–September 2007

USAID'S IMPLEMENTING AIDS PREVENTION AND CARE (IMPACT) PROJECT



USAID
FROM THE AMERICAN PEOPLE





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*Submitted to USAID
By Family Health International*

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Similarly, we are grateful to the Government of the Republic of Namibia, in particular, the Ministry of Health and Social Services, the Ministry of Gender Equality and Child Welfare, and the Ministry of Education for their guidance and continuous support. We would also like to thank our colleagues from Namibian and international organizations as well as the donor community for their collaboration in our endeavors.

Above all, however, we would like to thank the staff and volunteers from our implementing partners, who taught us almost everything we know in Namibia and made us fall in love with this country. It has been a great experience. We would like to thank the FHI/Namibia Team for its dedication and long hours of work to make this project a reality.

Last but not least, we would like to dedicate this report to Children of Namibia in the hope that we have helped make their future a little brighter.

On behalf of the FHI Team, I thank you all for your friendship and support.

Rose de Buysscher

Country Director, FHI/Namibia



Courtesy of *The Namibian*

ABBREVIATIONS

ACT	AIDS Care Trust
AFM	Apostolic Faith Mission
AFMAA	Apostolic Faith Mission AIDS Action
AIM	AIDS impact modeling
ALU	AIDS Law Unit (of the Legal Assistance Centre)
AMICAALL	Alliance of Mayors' Initiative for Community Action on AIDS at the Local Level
ANC	Antenatal care
ART	Antiretroviral therapy
ARV	Antiretrovirals
BCC	Behavioral change communication
CAA	Catholic AIDS Action
CAFO	Church Alliance for Orphans
CCN	Council of Churches in Namibia
CD	Country director
CDC	US Centers for Disease Control and Prevention
CHS	Catholic Health Services
COM	Chamber of Mines
CT	Counseling and testing
ELCAP	Evangelical Lutheran Church AIDS Program (ELCRIN)
ELCRIN	Evangelical Lutheran Church in the Republic of Namibia
ELCIN	Evangelical Lutheran Church of Namibia
FBO	Faith-based organization
FHI	Family Health International
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HAART	Highly active antiretroviral therapy
HAMU	HIV/AIDS Management Unit (Ministry of Education)
HBC	Home-based care
IEC	Information, education, and communication materials
LAC	Legal assistance centre
LMS	Lutheran Medical Services
M&E	Monitoring and evaluation
MoHSS	Ministry of Health and Social Services
MGECW	Ministry of Gender Equality and Child Welfare
MTP	Medium term plan
NANTU	Namibian Teachers' Union
NIP	Namibia Institute of Pathology
NGO	Nongovernmental organization
OHEAP	Occupational Health Education and Awareness program
OI	Opportunistic infections
OPD	Outpatient department
OVC	Orphans and other vulnerable children
OVC/TA	OVC Technical Advisor
OYO	Ombetja Yehinga Organization
PE	Peer educator

PEP	Post-exposure prophylaxis
PLHA	People living with HIV/AIDS
QAI	Quality Assurance and Improvement
RAAAP	Rapid Appraisal, Assessment and Action Planning Process
PEPFAR	US President’s Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother-to-Child Transmission
PSEMAS	Public Service Medical Aid Scheme
PSS	Psychosocial Support
RAAAP	Rapid Assessment, Analysis, and Action Plan
SIAPAC	Social Impact Assessment and Policy Analysis Corporation
SMA	Social Marketing Association of Namibia (PSI Namibia)
SN MPC	Sam Nujoma Multi-Purpose Centre, Ongwediva
STD/STI	Sexually transmitted disease/infection
TAF	Treatment Action Forum
TB	Tuberculosis
TOT	Training of trainers
TKMOAMS	Tate Kalunga Mweneka Omukithi wo “AIDS” Moshilongo Shetu (Almighty Father Help Us Stop the AIDS Pandemic in our Country)
USAID	US Agency for International Development
VCT	Voluntary counseling and testing
VSO	Voluntary Services Overseas
WHO	World Health Organization
WB MPC	Walvis Bay Multi-Purpose Centre
YEP	Youth Education Program

EXECUTIVE SUMMARY

With close to 20 percent of sexually active adults infected with HIV, the Republic of Namibia ranks among the countries most devastated by the disease. Under IMPACT, prevention of new HIV infections remains a priority, as well as the care, treatment, and support of those affected and infected by HIV/AIDS. Namibia is faced with the challenge of creating and sustaining comprehensive programs that manage the many facets of this disease.

Family Health International (FHI), with the support of the US Agency for International Development (USAID), implemented the Implementing AIDS Prevention and Care Project (IMPACT) in Namibia from September 2000 to September 2007, working to improve the health and wellbeing of the population. IMPACT/Namibia implemented a wide range of HIV prevention, care, and treatment programs targeting both the population at large and specific sectors of the population. Special focus was paid to youth, work force, orphaned and vulnerable children (OVC), pregnant women, and people living with HIV/AIDS (PLHA).

Nationally, IMPACT/Namibia worked primarily with the Ministry of Health and Social Services and the Ministry of Gender Equality and Child Welfare in support of their national HIV/AIDS and OVC programs, respectively, as well as AIDS services organizations. At the regional and local level, FHI worked primarily with NGOs and faith-based organizations (FBOs), the latter in recognition of broad penetration, existing leadership, and overall impact at the community level. FHI also worked with church and traditional leaders, especially in Namibia's northernmost populous regions.

IMPACT/Namibia prioritized youth programming, which targets young people and discourages unsafe sexual practices and helps them cope with the impact of HIV/AIDS. Activities were varied, ranging from a weekly reproductive health page in the daily newspaper, *The Namibian*, to programming and social service access through community development programs at municipal and other youth-friendly centers. IMPACT/Namibia's workplace programs targeted Namibian workers by building the capacity of local organizations to provide a comprehensive HIV/AIDS workplace package to all sectors of the workforce, through partners such as AIDS Care Trust, the Chamber of Mines, and the Walvis Bay and Sam Nujoma Multipurpose Centers.

OVC were the focus of many IMPACT-supported efforts. This included support to the National OVC Program of the Government of Namibia; a legal advocacy project to ensure the rights of OVC; and the psychosocial emphasis of Catholic AIDS Action, LifeLine/ChildLine and Philippi Trust, to make sure that OVC attend school, are cared for, and can cope with their losses.

In late 2003, with the support of the US President's Emergency Plan for AIDS Relief (PEPFAR), IMPACT/Namibia partnered with five faith-based hospitals and their community and faith-based affiliates to introduce voluntary counseling and testing (VCT), prevention of mother-to-child transmission (PMTCT), and antiretroviral therapy (ART) services. The project also worked with an active private health sector to provide treatment and care. In September 2004, Namibia's first faith-based integrated HIV services center was inaugurated at St. Martin's Catholic Hospital in Oshikuku. Three additional faith-based integrated centers were completed and continue to provide services to a mostly rural population in the northern parts of Namibia. With PEPFAR support, these centers provide more than 300,000 people with access to VCT, PMTCT, and

ART. By June 2006, the five faith-based hospitals had more than 5,800 people on treatment and more than 13,000 women had been tested and counseled for PMTCT services. By September 2006, the Government of Namibia, under the leadership of the Ministry of Health and Social Services, with support primarily from PEPFAR and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), had already reached its 3-by-5 WHO¹ as well as 114 percent² of its PEPFAR targets of 23,000 people on treatment. By the end of 2006, close to 30,000 people were on treatment in both the private and public sectors.

¹ The “3 by 5” initiative, launched by UNAIDS and WHO in 2003, was a global TARGET to provide 3 million PLHA in low- and middle-income countries with ART by the end of 2005.

² The Power of Partnerships: Third Annual Report to Congress on PEPFAR, 2007.

PROGRAM STRATEGIES, IMPLEMENTATION, AND RESULTS

INTRODUCTION

The IMPACT/Namibia project began in September 2000 when USAID/Namibia obligated an initial amount of US\$1.25 million to FHI to manage a multiyear prevention and care program in Namibia in support of Strategic Objective 5, “Increased service utilization and improved behaviors related to STDs and HIV/AIDS in target communities in Namibia.” The program was expanded in 2003 under the President’s Initial Program Proposal (IPP) for PMTCT, and improved care and support for women with HIV, their children, and their partners. Subsequently, Namibia became one of 15 countries funded under PEPFAR to include VCT, PMTCT, and ARV treatment services. IMPACT/Namibia contributed to the PEPFAR/Namibia-specific targets of 23,000 people on treatment, 72,000 infections averted, and 113,000 people receiving care and support in Namibia. Over the life of the project, IMPACT/Namibia received just over US\$19.5 million, of which more than 70 percent went directly to local implementing partners through direct grants and contracts, as well as procurement of equipment and services.

IMPACT/Namibia was designed to assist USAID/Namibia to implement effective interventions and increase the capacity of local organizations, and the public and private sector to assume increased responsibility for their HIV/AIDS Programs. IMPACT/Namibia provided technical support to national bodies, including the Ministry of Health and Social Services (MoHSS), the Ministry of Gender Equality and Child Welfare (MGECW), as well as the ministries of Education (MoEd) and Local Government and Housing (MLGH), for the effective integration of HIV/AIDS programming into key national structures and policies.

Geographically, IMPACT/Namibia initially focused on three regions: Khomas, Erongo, and Oshana. The five key municipalities targeted in these regions were Windhoek, Walvis Bay, Swakopmund, Oshakati, and Ongwediva. These five urban areas comprise about one-sixth of the total population of Namibia. With the implementation of the President’s International Mother and Child HIV Prevention Initiative, and subsequently under PEPFAR, the program expanded both geographically and programmatically to all 13 political regions of Namibia.

Over its lifetime, IMPACT/Namibia supported 25 prevention, care, and treatment programs. The prevention programs focused on youth, workforce, community members, and pregnant women; the treatment, care, and support programs focused on PLHA and OVC.

COUNTRY CONTEXT

The Republic of Namibia gained independence from South Africa on March 21, 1990, after more than 100 years of colonization and decades of armed and diplomatic struggle against apartheid and white minority rule. Namibia is a vast, sparsely populated country situated along the South Atlantic coast of Africa. By 2006, the population was just over 2 million with an annual growth rate of 2.6 percent. Namibia is the 31st largest country in the world, with the second-lowest average density (after Mongolia) of just over two people/km².

Most Namibians live in the north of the country, followed by the central plateau and the Walvis Bay-Swakopmund corridor at the coast. Although the country's population remains predominantly rural, the rapid growth of informal settlements around the country's towns and Windhoek reflects the significant increase in urbanization, ostensibly motivated by a search for economic opportunities. While some urban migrants do find regular employment, many are underemployed, unemployed, or self-employed in the informal sector. The high mobility of the population has also created serious social, security, environmental, and political problems for the urban areas, and contributes to the high level of female-headed households in rural areas and temporary relationships in urban areas.



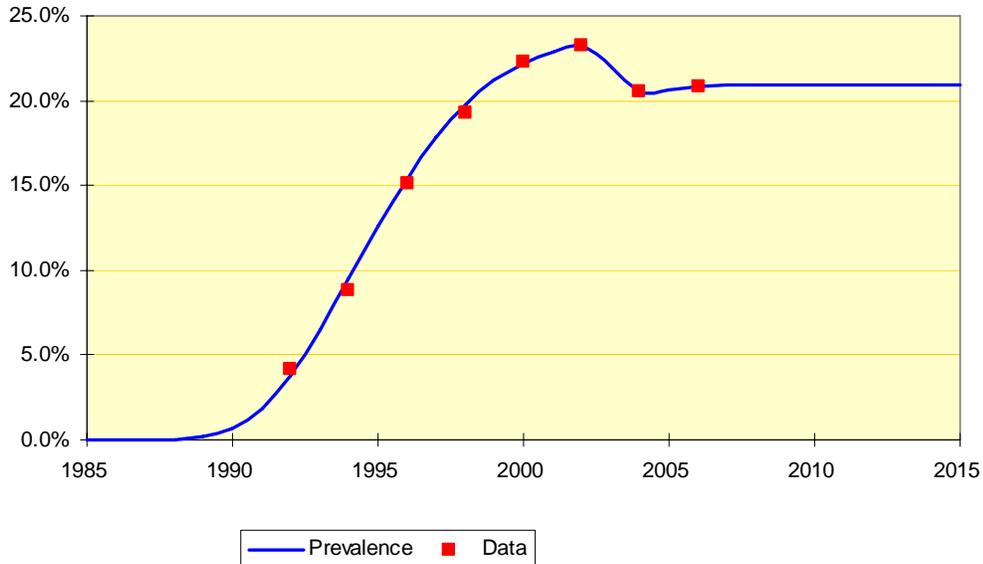
Namibia's income distribution is among the most disproportionate in the world, with the wealthiest 1 percent earning more than the poorest 50 percent combined. The gross national income per capita is US\$1,660. However, approximately 35 percent of the population lives on less than US\$1 per day and almost 56 percent on less than US\$2 per day.

Because of HIV/AIDS prevalence, Namibia's life expectancy decreased from 62 years in 1996 to 44 in 2006.³ The weighted national HIV

prevalence according to population per region among pregnant women dropped from 23.3 percent in 2002 to 20.5 percent in 2004 and was 20.8 percent in 2006. There was a decrease in HIV prevalence among 15- to 19-year-olds, from 12 percent in 2000 to 10 percent in 2004 but remaining at that level in 2006; and a decrease from 22 percent to 18 percent to 16 percent, respectively, in 20- to 24-year-olds, between 2002 and 2006. These figures suggest the epidemic is currently stabilizing at a level of about 20 percent among pregnant women, which means that the number of patients who will need to be enrolled in ART over the coming decades will remain higher than 20,000 per year unless highly effective prevention strategies are introduced.

³ The Power of Partnerships: Third Annual Report to Congress on PEPFAR, 2007.

Weighted HIV prevalence among pregnant women, Namibia 1992–2006



Namibia ranks among the top five countries most affected by HIV, with the highest rates in the northern most populous areas. A national consensus workshop in 2000 on the demographic impact of HIV projected that HIV prevalence would stabilize at 23 percent by 2002. The number of people living with HIV/AIDS is estimated to be 230,000.⁴ Namibia also ranks among countries with the highest burden of tuberculosis (TB), with a case notification of 822 per 100,000. Unlike HIV, the areas most affected by TB are in Karas (south) and Erongo (coast) with 1,603 and 1,484 TB cases per 100,000 reported respectively. In addition, the National TB Control Programme estimates that between 100 and 150 patients are treated for MDR-TB annually.⁵ In addition, malaria is a growing public health problem, and a leading cause of illness and death among children under five years old.

A study conducted by SIAPAC⁶ in 2000 projected that in 2006 there would be more than 180,000 orphans living in Namibia due to HIV. It is estimated that in 2006, there were between 150,000 to 180,000 OVC in Namibia. The 2006 OVC survey in the Omusati Region in Namibia⁷ found that three-quarters of households surveyed were taking care of orphans, with an average of two orphans per household, and households most often had a total of three to six children in the home. Very few caretakers reported that their income was sufficient, and more than half reported their incomes were lower or much lower than the previous year. Additionally, violence and abuse of women and children, especially girls, remains a major obstacle to children reaching their potential and realizing their rights. High levels of stigma and discrimination remain a stumbling block to effective care and support of OVC; 51 percent of youth surveyed said that they would not be friends with someone who had HIV/AIDS.

⁴ Southern Africa Overview, The Global Fund, 2006.

⁵ MoHSS, Namibia Global Fund Programme, Annual Report, January to December 2005.

⁶ A Situation Analysis of OVC in Namibia, SIAPAC for MoHSS and UNICEF, April 2002.

⁷ Survey of Orphans and Vulnerable Children - Baseline Survey Report, Project HOPE, 2006, Namibia.

Namibia's relevant policy framework includes the country's constitution, the UN Convention on the Rights of the Child (to which Namibia is a signatory), the Namibian Medium Term Plan III, and the National Strategic Plan on HIV/AIDS 2004–2009. The HIV Policy for the Education Sector (2003) provides excellent guidelines for prevention, care, and support of those affected by HIV and AIDS. The more recent National Policy on Orphans and Vulnerable Children (2005), developed and launched with the support of IMPACT/Namibia, provides a framework for all aspects of work involving orphans and vulnerable children. The National Policy on HIV, an effort led by the Legal Assistance Centre, went through a broad, consultative revision in 2006, and was officially approved by Cabinet on March 15, 2007.

IMPLEMENTATION AND MANAGEMENT

Implementation

Focus and support at both national and local levels was key to the comprehensive programming approach of IMPACT/Namibia. At the national level, the project supported the Government of Namibia through its work with the Ministry of Health and Social Services and the Ministry of Gender Equality and Child Welfare in the development and implementation of national guidelines and policies, as well the development of its Medium-Term Plans. At the regional level, IMPACT worked primarily through local government, NGOs, and FBOs to implement comprehensive programs for prevention, care, and treatment. This included community outreach and services for VCT, PMTCT, and treatment, care, and support for PLHA and OVC, prevention and impact mitigation, advocacy, policy dissemination, and capacity building.

IMPACT/Namibia worked with local implementing agencies (IAs) to carry out community-level activities through subagreements and a Rapid Response Fund Program. Contracts were used for purchased services in support of programs. IMPACT/Namibia had a Memorandum of Understanding with the MoHSS and the MGECW, respectively, detailing the OVC technical assistance to be provided through IMPACT/Namibia seconded staff, as well as other supports. The country office and the IAs determined technical assistance needs. These needs and plans were outlined in the annual work plan and were typically carried out by the country office technical staff or through local consultants. Priority was accorded to the use of local/regional technical assistance to conserve resources and assure continuity of services.

IMPACT/Namibia was dedicated to capacity building at all levels. This was mainly achieved through direct technical assistance by FHI country office staff and technical experts, rather than through the above funding mechanisms. Capacity building often took the form of conducting workshops and trainings, technical assistance in development of strategic plans, and/or review of guidelines, manuals and reports, as well as sponsorships to international and national conferences. Training technical support providers is essential to sustain HIV programming at both governmental and nongovernmental levels. In recognition that building national expertise helps provide more culturally appropriate support and ensures increased sustainability, IMPACT-driven trainings focused primarily on training of trainers (TOT) and master trainers. These individuals were responsible for training in their respective institutions, regions, or districts.

Management

Design and Management Structure

For effective coordination and support, IMPACT/Namibia was managed from the FHI country office based in Windhoek. The office was headed by a country director (CD), who supervised and was supported by a team of technical, program, and financial staff. During the first three years of the project, the FHI country office also managed the Walvis Bay Multi-purpose Centre (WB MPC), and its staff reported directly to the CD. Subsequently, the WB MPC graduated from direct FHI support to become an independent trust. The CD was accountable to USAID/Namibia for achieving the proposed results under USAID/Namibia's SO5, and subsequently the PEPFAR program goals and indicators.

The FHI office in Arlington, Virginia, provided overall management support to the program. An associate director and senior program officer provided immediate backstop support while other program staff assisted the Namibia program with monitoring, program, and administrative assistance as needed. Technical program resources were made available in all areas as requested.

Financial Management

FHI was fiscally accountable for the program and provided the appropriate level of financial oversight. All project recipients were subject to routine financial reporting requirements as outlined in their agreement and per USAID regulations and to internal audits as required by USAID and deemed necessary by FHI and USAID/Namibia. The country office submitted monthly financial reports to FHI/Arlington from which quarterly financial reports were submitted to USAID. Pre-award audits were conducted for all IAs receiving more than US\$50,000 while those expending more than US\$200,000 were subject to external audits.

Monitoring and Reporting

The country office submitted quarterly reports to USAID/Namibia and semiannual program reports to FHI/Arlington, which were combined with other IMPACT projects around the world and submitted to the USAID/Global Bureau.

The IAs funded, through subagreements and contracts, submitted financial reports, narrative reports, and process indicator forms to the country office as specified in their agreements. FHI determined appropriate reporting formats and assured that evaluation indicators were collected and reported to USAID regularly. In addition, IA activities were monitored through regular meetings and field and site visits. Meetings with IA staff were usually convened before or after the monthly USG meetings at USAID/Windhoek. These meetings also provided IAs the opportunity to network, share information and experience, discuss challenges and lessons learned, inform each other about upcoming events and activities, and a forum for sharing technical updates.

Implementation Constraints

Although there are relatively good roads between most urban centers, travel within Namibia is often long, arduous, and invariably expensive. In rural areas, there are only gravel roads and sand tracks subject to windstorms and flooding during the rainy season. For volunteers who must walk

to conduct home-based care visits or provide support to OVC, and for patients seeking treatment at district hospitals or clinics, the distances involved constitute a major constraint.

In most aspects of community mobilization and HIV mitigation, Namibia suffers from inadequate human resources. The main reason for this is historic: until independence in 1990, there was no tertiary institution within the country for people of color, nor does a medical or pharmacy school currently exist. Therefore, Namibian hospitals have a severe shortage of medical staff, and rely heavily on doctors and pharmacists from neighboring countries. In addition, because of the remote location of some of the hospitals, it is difficult to hire or keep medical staff in these locations. To ensure retention of staff, IMPACT/Namibia provided supplementary training, coaching, support, and constructive supervision to its implementing partners, as well as extensive infrastructure upgrading in remote areas.

Another consequence of Namibia's poor economic state is that most grassroots work depends on volunteers, many of whom are already caring for sick people and orphans in their own homes in addition to caring for others in their community. While this situation can persist, eventually volunteers demand more incentives to continue or burn out. Strategies are underway to address these challenges through the efforts of the MoHSS, which has called several workshops to develop national guidelines for volunteers, working conditions, training, and incentives.

FHI Namibia Timeline	FY00	FY01				FY02				FY03				FY04				FY05				FY06				FY07									
		1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4						
Develop, promote, and implement guidelines to improve the quality of services																																			
TA to MoHSS development of national ART guidelines								x	x	x	x																								
TA to MoHSS development of national PMTCT guidelines										x	x	x	x																						
Prevention—labor force and youth																																			
Implementation of workplace programs with IAs				x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x				
Development of materials in support of workplace programs				x	x	x	x	x	x	x	x	x	x																						
Opening of Walvis Bay and Sam Nujoma youth-friendly multipurpose centers				x								x																							
Implementation of youth programs with MPCs, FBOs, and NGOs				x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x					
Prevention—PMTCT																																			
Baseline assessment PMTCT																																			
Building/renovations/upgrading of integrated ANC/PMTCT centers																																			
Implementation of PMTCT with faith-based hospitals and FBOs																																			
Training in PMTCT counseling/national guidelines																																			
Development of materials in support PMTCT counseling and training																																			

FHI Namibia Timeline	FY00	FY01				FY02				FY03				FY04				FY05				FY06				FY07			
		1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
ART treatment services																													
Upgrading of hospital facilities for integrated ART services																x	x	x	x										
Training in ART national guidelines/counseling																x	x	x	x	x	x								
Initiation and continued provision of ART services at five faith-based hospitals																		x	x	x	x	x	x	x	x				
Development of counseling materials for community counselors in adherence and support																						x	x	x	x	x			
SI, Capacity building																													
Conduct economic assessment of five key municipalities																													
Technical advisors seconded to MoHSS																													
Assist MoHSS with sentinel surveillance and epidemiological report																													
Capacity building of local NGOs: program and financial management; strategic plans, proposal writing, monitoring and evaluation																													

PROGRAM OBJECTIVES, STRATEGIES, AND ACTIVITIES

The IMPACT/Namibia project was originally designed to provide support for HIV prevention and care activities in three regions: Khomas, Erongo, and Oshana. Activities focused on youth, the work force, and OVC under USAID/Namibia Strategic Objective 5 (SO5): “Increased service utilization and improved behaviors related to STDs and HIV/AIDS in target communities in Namibia.”

The objectives of IMPACT/Namibia under SO5 were:

1. To change behavior through peer education; counseling and outreach; small and mass media in the workplace; at schools and surrounding communities; and municipalities.
2. To strengthen the existing capacity of Namibian institutions in five key municipalities to respond with quality services to the increased demand for counseling and HIV testing, referrals, and other health-seeking behaviors.
3. To strengthen the capacity of the Government of Namibia, communities, and NGOs to support and educate vulnerable children support and education to keep orphans and vulnerable children in school, to destigmatize infected and affected children, to advocate for public and private support mechanisms, and to strengthen existing support services.

With the advent of PEPFAR, the strategy was greatly expanded in terms of geographical reach and program areas. Relying on its three-year experience and excellent relations working with FBOs, IMPACT/Namibia engaged in new partnerships with faith-based hospitals and organizations to achieve the additional objectives and targets under PEPFAR to rapidly scale up prevention and support services to meet the Namibia Emergency Plan’s targets of 23,000 people on treatment, 72,000 new infections averted, and 113,000 people receiving care and support by 2008. To reach its objectives, IMPACT/Namibia modified its original strategy to include treatment, care, and support for people affected and infected by HIV:

1. Work at the systems, community, family, and individual level to achieve a multisectoral and comprehensive response to the HIV pandemic by creating a supportive legislative and community environment in which eligible families and individuals receive assistance, based on their own determination of needs and strengths.
2. Partner with FBOs as the leading local organization in most communities, with built in leadership, positive social values, a widespread network for communication and outreach, and voluntary human resources.
3. Build the technical and management capacity of government, NGOs, FBOs, and the private sector to maximize access to available benefits (e.g., health, education, and social services) and add services where needed, such as home-based care (HBC) and OVC support.
4. Prevent HIV infections with a focus on empowering youth, women, the labor force, and the community at large through the use of both behavior formation and behavior change interventions.
5. Provide comprehensive integrated one-stop prevention, care, and treatment services for easy access to PMTCT, counseling and testing, prevention and management of opportunistic infections, and HIV treatment.

Considering the increasing evidence from PMTCT and ART programs in developing countries about the importance of community involvement for achieving high uptake of services and treatment compliance, IMPACT/Namibia used its technical and managerial expertise to intensify the collaboration with local organizations, especially FBOs. Through a strategy of institutional strengthening and promotion of networking, IMPACT/Namibia built a durable organizational capacity of FBOs to provide high-quality comprehensive prevention, care, and treatment services at both the hospital and community level.

Based on the results of the IMPACT baseline PMTCT assessment and focus group discussions conducted with managers and health workers from the five faith-based hospitals, IMPACT/Namibia proposed a comprehensive approach for the provision of counseling and testing, PMTCT, and clinical care and ART through integrated ANC/PMTCT/ART/CT centers. These integrated centers at the five mission district hospitals⁸ would establish strong links with outpatient departments (OPDs), hospital wards, TB services, and community-based services for home-based care and support for OVC.

The rapid establishment of integrated services with strong community links was expected to provide an example of successful interventions that could be used as a best practice for other district hospitals in Namibia. IMPACT/Namibia implemented its strategy of establishing integrated services with strong community links so that it could focus entirely on achieving the objectives and targets of the President's Initiative and PEPFAR, and build the technical and managerial capacity of the local partners to eventually receive direct funding from US Government institutions.

IMPACT/Namibia worked closely with the Ministry of Health and Social Services, the Lead Ministry for the national multisectoral response to HIV/AIDS in Namibia to ensure that the program contributed to the national response to HIV. The comprehensive framework for the national response is described in the country's medium term plan (MTP), approved by the National Multisectoral AIDS Coordination Committee and endorsed by Cabinet. The MTP provides a comprehensive strategy for the effective management and control of the HIV epidemic and a road map for all partners, as its aim is to involve all sectors—public, private, and civil society—to contribute to the national response to HIV and AIDS. IMPACT supported the Lead Ministry to carry out an external evaluation of the second medium-term plan for HIV/AIDS (MTPII) as well as the development of MTPIII 2004 to 2009).

Assessing the Impact of HIV on Five Key Municipalities

In 2001, at the request of the City of Windhoek, IMPACT/Namibia funded and provided technical assistance to conduct the HIV/AIDS Impact Assessment in five key municipalities: Ongwediva, Oshakati, Swakopmund, Walvis Bay, and Windhoek. The assessment was the first of its kind in Africa and was carried out by the Social Impact Assessment and Policy Analysis Corporation (SIAPAC), a local research organization contracted by FHI. The immediate purpose of this study was to assess the current and projected impact of HIV/AIDS on the functioning of the municipal authorities (the "internal impact" on municipal staff in terms of sick leave, deaths, training needs, etc.) and the impact on the population in the municipality (the "external impact" projected population growth, adult deaths, orphans, ability to pay for utilities, taxes, etc.).

⁸ The fifth hospital, St Mary's in Rehoboth, worked closely with the MoHSS ANC health centre to implement PMTCT and ART.

The study estimated the financial burden of HIV/AIDS on municipal staff budgets over the coming years. For the city of Windhoek alone, the additional cost for personnel was estimated at more than US\$400,000 per year due to sick leave, productivity declines, deaths, increased training costs, and recruitment costs. HIV/AIDS will also have an impact on the revenues of businesses, increase the demand for health and social services, and reduce the ability for poor households to pay essential services such as water and electricity.

The impact assessment has mapped the challenges for local authorities. A participatory process was used throughout the full study period under guidance of an advisory committee, by means of national workshops, focus group discussions, and local stakeholder meetings. This process ensured that municipal staff gained a better understanding of the impact of HIV/AIDS on the functioning of the municipality. Each of the participating five municipalities prepared a comprehensive action plan during a planning workshop, including workplace programs for municipal staff and prevention, care, and support programs for community members.

The initial findings of the HIV impact assessment at the municipalities were presented to the annual general meeting of the Namibian Association of Local Authorities Officers (NALAO) in November 2002. The official launch and presentation of the Summary Findings and Report, including the five municipal action plans, took place during a meeting hosted by the City of Windhoek in March 2003. More than 95 representatives from donor agencies, public and private sector, NGOs, local government, and the press attended the meeting. Four of the five municipalities have an HIV policy that is approved by their municipal councils, and all of the municipalities presented their action plans to their respective councils for consideration and inclusion in the budget for the coming financial years. Four of the five municipalities have an active HIV-prevention program funded by their respective municipality.

A follow-up workshop was organized in July 2003 for 10 additional municipalities: Eenhana, Grootfontein, Karibib, Katima Mulilo, Mariental, Omaruru, Ondangwa, Otjiwarongo, Outapi, and Usakos. Municipal officers who had participated in the impact assessment assisted in the facilitation of this workshop. During the workshop, participants learned basic facts about HIV/AIDS, assessed risk situations in their own municipalities, shared experiences about HIV municipal policy formulation and municipal responses and prepared draft action plans.

IMPACT/Namibia assisted the Alliance of Mayors' Initiative for Community Action on AIDS at the Local Level (AMICAALL) and its partners in preparing a proposal for the GFATM which was awarded in 2004 and ensured the further expansion of the integration of HIV activities after IMPACT support ended in 2003.

PMTCT Services Baseline Assessment

By 2003, all five mission hospitals had initiated some PMTCT activities before IMPACT/Namibia started supporting these services. A baseline assessment was carried out in September and October 2003 using the comprehensive baseline assessment tool developed by FHI and the Elisabeth Glazer Pediatric AIDS Foundation. This assessment looked into the available physical infrastructure, equipment, supplies, general antenatal care (ANC) services, counseling services for HIV testing, maternity services, training of staff and referral services

including STD treatment, contraception, post-natal care and child health services. In addition, exit interviews were held with ANC clients at all sites.

According to the baseline assessment, supplies for ANC and maternity services (gloves, iron and folic acid, ANC laboratory services, antenatal cards) were universally and continuously available at all sites. STD treatment and contraception was available through referral to another health worker within the hospital compound. All pregnant women received group information on PMTCT, and those who were interested in receiving PMTCT services were referred to a separate counseling room in another area of the hospital. HIV testing was only done on-site at one of the mission hospitals and positive tests were sent to Windhoek for confirmation, resulting in an average of more than two weeks delay in receiving results.

The space available for ANC services and counseling was insufficient to provide routine counseling and testing for all pregnant women. None of the hospitals had adequate space for the provision of integrated ANC, counseling, and testing and services for the management of HIV, including ART.

During exit interviews, ANC clients expressed that they were generally satisfied with ANC services. Most women expressed interest in receiving PMTCT services if they were treated efficiently in an integrated package at a “one-stop shop” setting. Several ANC clients also questioned the rationale of offering ARVs to prevent infections in infants without offering treatment to the mother.

With the exception of Rehoboth⁹, where uptake of PMTCT services was close to 100 percent, uptake of PMTCT services was low in the other four hospitals and attrition at each step of the PMTCT process was high. IMPACT/Namibia used the results of the assessments as basis for its integrated PMTCT+ program under the President’s Prevention of MTCT Initiative and its subsequent expansion to include CT and ART under the expanded USG PEPFAR Program.

Behavior Change Communication

Youth Programming: To mitigate the impact of HIV/AIDS on youth, IMPACT/Namibia supported youth programs both at the national and regional level. IMPACT/Namibia made programming among youth a priority, targeting in- and out-of-school youth to strengthen their ability to avoid unsafe sexual practices and to cope with the impact of HIV/AIDS. Youth programs emphasized communication skills and self-esteem and encouraged open discussions on reproductive health. IMPACT/Namibia primarily focused on empowering the youth to assume responsibility for their health through a comprehensive peer education strategy. For this purpose, information materials were developed or adapted and disseminated and services offered for youth, including skills building in reproductive health education, care and support, counseling as well as computer literacy and writing skills.

At the national level, IMPACT/Namibia supported the Reproductive Health page of the *YouthPaper*, a 12-page weekly insert in *The Namibian*, the only daily English-language newspaper in the country. *YouthPaper* provides Namibian youth with up-to-date information on reproductive health, including HIV/AIDS. FHI technical staff contributed to and reviewed

⁹ St Mary’s Rehoboth received private donor funding for its program

articles on reproductive health; reviewed write-ups, poems, and essays by contributing youth; and assisted with workshops organized by *YouthPaper*. With support from FHI and UNESCO, *YouthPaper*, published and distributed two booklets capturing the best essays and poems submitted by young people, “Caring for People living with HIV/AIDS” and “How Should We Care for our AIDS Orphans?” 15,000 copies were distributed to schools, and disseminated during workshops and conferences. Through this dissemination vehicle, an estimated 100,000 youth were reached weekly over a six-year period. On average about 20,000 copies of the Namibian are sold each day. In addition, 5,000 copies of the Namibian Youth Paper are distributed to school libraries around the country. IMPACT/Namibia supported the reproductive health page of the *YouthPaper* as well as contributing articles on HIV-related topics.

At the community level, IMPACT/Namibia’s youth program ranged widely from social service access through community development and life skills programs at the Walvis Bay and Sam Nujoma youth-friendly multipurpose centers. In- and out-of-school programs included the participatory school drama “Feeling Yes, Feeling No” implemented by LifeLine/ChildLine, making children aware of sexual and other abuse, and empowering them with skills to address it. The Catholic AIDS Action after school Youth Education Program (YEP) implemented through their 14 regional offices using Adventure Unlimited and Stepping Stones curricula focused on both younger and older youth. The Ombetja Yehinga program worked in the Kunene and Erongo regions and focused on in-school youth involving teachers and peers, using drama, songs, contests, fashion shows, youth clubs and a quarterly youth magazine by and for youth, addressing issues ranging from alcohol and drug abuse to safer sex, self-esteem, and reproductive health. Philippi Trust’s kids and youth clubs reached vulnerable children with support and grief counseling and activities to build friendship, trust, and self-esteem, as well as empower them to abstain from sex as a primary HIV-prevention strategy.

Workplace and community outreach: IMPACT/Namibia supported a comprehensive workplace program targeting both the public and private sector using peer education. The program was implemented by the Chamber of Mines, AIDS Care Trust (ACT), the AIDS Law Unit (ALU) of the Legal Assistance Centre and the Multipurpose Centers in Walvis Bay and Ongwediva. During the first phase of the project, IMPACT/Namibia worked closely with its partners to develop a training package through a series of consultative meetings, workshops, and field-testing with staff from partners and selected workplaces on the messages and materials. The package consisted of a training manual, a peer educator how-to practical guide for monthly sessions and handouts, an accompanying illustrative flipchart, and a PMTCT information booklet. It also included lists for referral services, and appropriate materials available from the National Take Control Program, the Ministry of Health and Social Services, the legal assistance centre, and other NGOs. The training materials were translated into two additional languages, Oshindonga and Afrikaans. The educational flipchart and how-to booklet were revised in 2006 to include TB and ART treatment information.

In support of the workplace program, the ALU worked closely with the IAs to develop and implement workplace policies consistent with the National Code on HIV/AIDS and Employment, as well as providing training and legal advice in support of the peer education programs. The workplace program focused primarily on mining, fishing, and associated service industries as well as four municipal workforces (Windhoek, Swakopmund, Walvis Bay, and Ongwediva). In addition, the program targeted places where workers congregate after work, such

as *shebeens*, and through special community outreach events. Behavior change messages focused on promoting abstinence, faithfulness, and consistent condom use, as well as health-seeking behaviors such as treatment for STIs, promotion of counseling and testing, and initiating PMTCT and ART. The workplace program required each company to have a drafted HIV/AIDS policy in place to ensure management commitment to supporting the initiative over time. The underlying objectives of the comprehensive approach, with the assistance of the ALU, were to:

- Provide protection for workers living with HIV/AIDS from discrimination and exclusion from the workplace.
- Promote a human-rights-based approach to HIV prevention in the workplace through proactive commitment by management to avoid stigma and discrimination.
- Implement comprehensive and effective HIV/AIDS peer education prevention and care programs, with outreach to families and the community.

Most HIV/AIDS workplace activities supported by the program leveraged matching funds from the business community they served through a variety of ways, such as provision of a venue, transport, or provision of food. The IMPACT/Namibia-supported workplace program was managed as a fee-for-service program with the intention of making it more self-sustaining by building the capacity of the NGOs to provide quality services to its customers. Companies typically paid a set fee calculated on the size of the company workforce for training and supervision of its peer educators. The FHI workplace peer education materials were widely distributed and used in Namibia, including the private sector, which reproduces the materials for use within their programs.

OVC and other children affected by HIV/AIDS: IMPACT/Namibia's activities aimed at improving the lives of OVC and families affected by HIV/AIDS by placing strategic emphasis on strengthening the ability of local communities and FBOs to meet their needs. In conjunction with three government ministries—ministries of Health and Social Services, Gender Equality and Child Welfare, and Education—FHI aimed to create a supportive social and policy environment that would help communities, families, children, and adolescents meet their own needs as much as possible.

As the number of OVC began to rapidly increase in Namibia, from 30,000 in 2000 to an estimated 150,000–180,000 in 2006, FHI scaled up its efforts to provide comprehensive support for children affected by HIV/AIDS, especially in the most heavily affected areas of the north, central, and coastal areas of the country. The IMPACT/Namibia strategy further called for a strengthened and enabled environment for OVC programming at the national level, and the capacity building of local FBOs and NGOs to provide support to OVC through community-based volunteers. In addition to its work with government (particularly the Ministry of Gender Equality and Child Welfare), IMPACT/Namibia worked initially with CAA, the legal assistance centre, Philippi Namibia, and Lifeline/ChildLine in the area of OVC support, and later expanded its partnerships to include the Walvis Bay and the Sam Nujoma Multi-Purpose Centers as well as various FBOs, such as ELCAP, ELCIN AIDS Action, the Rhenish Church AIDS Program, the Apostolic Faith Mission AIDS Action, and TKMOAMS. Together with the *YouthPaper*, LifeLine/ChildLine and Ombetja Yehinga, IMPACT/Namibia disseminated information about OVC care, support, and resilience-building through mass media, theatre, and artistic expression.

In keeping with the national medium term plans II and III on HIV/AIDS, IMPACT/Namibia built its programs on existing structures and organizations, keeping in mind that OVC are best served in a family environment, and that OVC should be able to enjoy the same supports and opportunities as other children their age. Thus, Namibia's program initially focused on expanding educational development opportunities for OVC and developing community and faith-based support systems that encouraged their inclusion and care without fear of stigma or discrimination. This also included the mobilization of local church and community leaders to create a supportive environment for children, as well as the training and follow-up support of local volunteers and caregivers to serve as friendly visitors, advocates, and direct-care providers of children in need. By 2003, a multivariate approach emerged:

- At an individual level, IMPACT/Namibia placed special emphasis on psychosocial support of OVC through experiential learning camps, after school programs, supplemental nutrition, and HBC by specially trained volunteers. Children in child-headed households or with special needs (therapy, medical treatment, etc.) were referred to professional services when available.
- At a family level, the activities under IMPACT/Namibia included the training of community volunteers and caregivers, the provision of nutritional guidance and some additional food supplements, and above all, support to HIV-infected parents and other relatives (including children) to keep them alive and healthy for as long as possible through positive living, CT services, and both referral and follow-up for ART. The training of caregivers and volunteers always included basic information on child development, grief and bereavement, child rights (including identifying available resources and referral), HIV prevention and care, and active listening and response skills.
- At the community level, IMPACT/Namibia focused on integrating OVC into community life as much as possible, to ensure access to education, adequate health care, and legal assistance if needed.
- At the national level, IMPACT/Namibia supported the Ministry of Gender Equality and Child Welfare's National Program for Action for Children, and the OVC Permanent Task Force, which guides OVC programming in the country by providing a long-term technical advisor at the Ministry. The National Task Force was established after the first National OVC Stakeholders Conference held in 2001 with support from IMPACT/Namibia and UNICEF. As part of the OVC PTF mandate, IMPACT/Namibia through the legal assistance entre, supported the Ministry in the development of the National OVC Policy, which was launched by the President of Namibia at the third national OVC conference in February 2005, co-funded by IMPACT/Namibia and UNICEF. Various training guides and publications reinforced best-practice skills, training principles, and information about available resources, such as a brochure on how to apply for a social welfare grant at the Ministry of Gender Equality and Child Welfare.
- At the national and regional level, IMPACT/Namibia supported the "Quality Improvement of OVC Services" sponsored jointly by USAID/Namibia and the USAID Africa Bureau. In 2006, the USAID Africa Bureau through FHI facilitated a process for partners working with OVC to develop a shared set of outcomes and standards of practice for service areas for

quality improvement and assurance. This included reaching an agreement on minimum characteristics in seven key domain areas: psychosocial support, education support, protection, shelter and care, health, food and nutrition, and economic strengthening/opportunity. Consultations with key implementing partners, the Government of Namibia, as well as NGOs and FBOs working with vulnerable children resulted in “Outcomes and Quality Standards for Core Services: An initial guideline for partners in Namibia working in support of orphans and vulnerable children.” This process was informed by the facilitation guide “Achieving Quality Care for Children Affected by HIV/AIDS: A Facilitation Tool for Defining Standards of Care,” developed by a core team from Africa and US experts. IMPACT/Namibia participated in the pilot introduction of the Facilitation Guide in Ethiopia in February 2007. Subsequently, the IMPACT/Namibia OVC Team used the knowledge gained from the pilot to train key stakeholders in Namibia, Zimbabwe, and Tanzania.

Provision of comprehensive care and support

The IMPACT/Namibia care and support program sought to increase the capacity of FBOs and NGOs to support family members and community caregivers in their care and support of OVC and PLHA through training, supervision, and provision of supplies. Strategies focused on supporting the Government of Namibia through its line ministries to ensure that the necessary laws and services were in place to ensure care, and that basic rights are upheld. The strategies also focused on expanding existing church infrastructures with its large numbers of community caregivers and volunteers. Training and support of these volunteers and their supervisors (staff from local FBOs and community-based organizations) initially focused on the provision of home-based care (HBC) to PLHA. From this foundation, a wide range of nutritional, prevention-education, psychosocial, and advocacy (information, referral and follow-up) services were developed for the entire family, with an increased focus over time on OVC. Ongoing advocacy and sensitization led to a close cooperation between traditional kings and headmen in the north, who take the lead in calling together their constituency for training and community outreach.

Community Support and Home-Based Care

IMPACT/Namibia supported the recruitment, training, supervision, ongoing support, and monitoring and evaluation of volunteers providing HBC services at the community-level in 12 of the country’s 13 political regions. The training and support of these volunteers took place in accordance with standards set by the Ministry of Health and Social Services. However, the Ministry of Health would often turn to FHI implementing partners for guidance in home-based care, particularly in the setting of standards and training. Volunteers visit the homes of sick patients at least once per week, provide counseling, spiritual support, household assistance, personal care, and referrals where necessary. They are particularly attuned to the signs and symptoms of HIV and common opportunistic infections (OI), and provide training to household members to provide care when the volunteer is not around. Based on the home-based care that is provided, the volunteers also build relationships relevant to the care and support of OVC in the household.

FBOs provide the vast majority of HBC in Namibia, dominated by those receiving support from IMPACT/Namibia. Through their partnership with CAA and Philippi Namibia,

IMPACT/Namibia supported the development of additional HBC training curricula, and the development and implementation of quality-assurance standards.

The CAA TOT model to transfer knowledge and skills consists of four modules for a total of 160 hours. The fourth module, supported by IMPACT, focuses on psychosocial support. Trained individuals then return to the field offices and train other CAA staff and volunteers in the provision of HBC over a two-week, 84-hour curriculum. Following CAA's lead, other FBO providers adopted the same approach, resulting in national uniformity.

IMPACT/Namibia also supported the TOT of each implementing agency's staff and senior volunteers who took responsibility within their respective organizations for the provision of HBC. The program also funded the ongoing management and quality assurance of HBC and provided for limited HBC supplies and small incentives needed to keep these programs active and meaningful at the community level. Incentives included an HBC t-shirt upon graduation from the course as well as an umbrella to active volunteers.

ELCAP in the south and west, and ELCIN in the north, greatly expanded their HBC and community outreach programs under PEPFAR. CAA and ELCIN AIDS Action jointly organized the first ecumenical TOT for HBC and counseling in Oshindonga. The three-module course of two weeks each was completed over a nine-month period (after completing each module, volunteers practiced under the supervision of a trained HBC) and had participants from ELCIN, CAA and the Apostolic Faith Mission Church. With support from PEPFAR, IMPACT/Namibia built the capacity of the FBOs by training volunteers in information, referral, and follow-up support for VCT, PMTCT, and ART clients in their communities. In support of these caregivers, LifeLine/ChildLine conducted 100-hour personal growth and basic counseling training workshops in local languages throughout Namibia to ensure that a pool of quality community volunteers and counselors would be available to meet the increasing demand to support people infected and affected by the epidemic. Due to the rapid scale, scale-up of PMTCT and ART services in the IMPACT-supported faith-based hospitals, and to ensure provision of continuum of care within the community, LifeLine/ChildLine, with technical support from IMPACT, developed four additional community counseling training modules with technical support from FHI to further develop the skills of community volunteers and counselors.

Establishment of comprehensive integrated services for prevention, care, and treatment

Prevention of mother-to-child transmission

IMPACT/Namibia based its PMTCT strategy on its previous experience with FBOs, their capacity to quickly mobilize, and on the results of its baseline facility assessment and interviews. As a result, the IMPACT/Namibia strategy focused on providing integrated PMTCT+ services through the five faith-based hospitals and to conduct community outreach and mobilization through the Catholic and Lutheran affiliated FBOs, CAA, ELCAP, and ELCIN.

To effectively scale up services, as learned from the baseline assessment, it was essential to upgrade the infrastructure by remodeling and extending existing structures at the Catholic Health Services (CHS) and Lutheran Medical Services (LMS) mission hospitals to ensure confidential counseling and testing services in support of PMTCT+. IMPACT/Namibia also worked with the

management of the five hospitals to improve service delivery and implemented a comprehensive and integrated “one-stop shop” service for ANC clients in each of the hospitals’ catchment areas, to increase efficiency, and facilitate referral of pregnant women for clinical assessment and treatment, where indicated.

The faith-based hospitals in Namibia are subsidized by the government and operate district hospitals that are fully integrated into the public health system. The faith-based hospitals are responsible for their own staff recruitment and management and are owners of the hospital premises. The process of recruiting additional staff for PMTCT and CT services (including health professionals and community counselors) and renovating and/or extending physical infrastructure was therefore easier for the LMS in Onandjokwe and CHS operating three hospitals in the North and one in the South, than for government hospitals. Support from IMPACT/Namibia enabled these hospitals to respond very efficiently to the specific needs of establishing integrated services and hiring additional staff to improve service delivery.

The first integrated VCT/ANC/PMTCT center at St. Martins Catholic Hospital in Oshikuku was officially opened by the USAID/Namibia mission director in early 2004, and the last and largest center, serving the Oshikoto area, the Lutheran Medical Services’ Shanamutango Centre opened for comprehensive integrated services by November 2004. Training in PMTCT was conducted by FHI staff in collaboration with the MoHSS/CDC and ITECH using the MoHSS PMTCT guidelines. Development of training curricula of community counselors in PMTCT was provided by FHI technical experts in concert with LifeLine/ChildLine for both the faith-based and public district hospitals operated by the Government of Namibia. Community counselor volunteers were trained by LifeLine/ChildLine to support behavior change such as risk reduction, adherence to ART, safe infant feeding, and positive living.

The rapid establishment of integrated, efficient, and quality services at the faith-based hospitals with strong community links through their faith-based affiliates and other community organizations contributed to the success and high number of women accessing the services.

Counseling and Testing

The IMPACT/Namibia strategy on counseling and testing is based on adapting the traditional approach to counseling to the specific needs of HIV-related services with specific objectives and tasks, respectively for medical and counseling staff. This counseling approach provides a universal framework for HIV counseling that is applicable to a wide range of services from CT, through PMTCT and adherence. The approach enables counselors to focus on the whole person, putting HIV in the context of the client’s life, not simply isolating their sexual behaviors, risk patterns, or treatment needs. This strategy is therefore focused on counseling skills development that are client-centered using a wide range of experiential and participatory learning exercises, discussion, practical examples, and role-plays to build the essential counseling skills. It also strengthens the capacity of service providers to deliver comprehensive services as an interdisciplinary team that optimizes the contribution of all team members. In this interdisciplinary team, the healthcare providers can primarily focus on medical options, providing specific factual health information at the appropriate time, and diagnosing and treating medical problems. The community counselor can then focus on emotional and psychosocial support as well as making sure the client understands important health-related issues, thereby

supporting the client in any targeted behavior change such as risk reduction, adherence to ART, safe infant feeding, or positive living.

The strategy of offering routine counseling and rapid testing at all facility-based points of service, particularly in ANC and TB services, was adopted by the health facilities supported by FHI to increase uptake of the service and increase the number of people knowing their serostatus.

In addition to supporting extensive infrastructure (facility upgrading) and human resources at the five mission hospitals, IMPACT/Namibia also supported facility upgrading at three VCT centers: two operated by the Evangelical Lutheran Church of the Republic of Namibia AIDS Program (ELCAP) in the south of the country, with one providing CT services and referrals to St. Mary's Hospital in Rehoboth; and a third VCT center at the Walvis Bay multipurpose centre, which was managed by the FHI country office, until it became an independent trust in May 2005.

Provision of HAART

From the outset, the IMPACT project communicated with its partners the vision of establishing integrated PMTCT, CT, HIV management, and ART services. These services should have strong links with TB, STI, family planning, and HBC services, as well with hospital wards providing care for patients diagnosed with HIV. The purpose of these integrated services was to ensure efficient diagnosis and care for patients with HIV. This integrated service acts as a referral point to which other services could refer patients (ANC, TB clinics, hospital wards, OPD departments, peripheral health centers, and clinics). In turn, the integrated centre refers patients for specific support or routine care to peripheral health centers, clinics, and HBC organizations.

Initially, the focus of the IMPACT/Namibia program was on establishing the capacity for PMTCT and CT services in line with the initial priorities of the emergency plan. When the scope of the emergency plan broadened to include ART, IMPACT/Namibia expanded its support to the five hospitals to integrate ART services into ongoing CT and PMTCT services by additional upgrading of the infrastructure required for ART services including laboratory, pharmacy, ARV dispensing, and treatment rooms. The hospitals were also provided with start-up drugs through FHI procurement on behalf of the MoHSS Central Medical Stores, which is responsible for supplying all government supported hospitals. Together with the MoHSS and CDC/ITECH, IMPACT/Namibia supported the training of health facility staff at all levels in drug adherence, clinical HIV management, including OI/STI/TB identification. In addition, a computerized patient management system was developed with support from IMPACT/Namibia.

Building upon the existing capacity and relationship between the five faith-based hospitals and their FBO partners, IMPACT/Namibia supported demand creation as a key strategy through community outreach and support, and build the ability of PLHA and community volunteers to support adherence to treatment. In support of the integrated services, IMPACT/Namibia funded LifeLine/ChildLine to adapt existing and develop/field-test new modules for community counselors to meet the rising demand for counseling and support services, as well as providing technical experts to train their team of trainers.

Promoting quality HIV care in the private health sector

Namibia has a thriving private health sector with the vast majority of Namibian clinicians working full- or part-time in this area. IMPACT/Namibia recognized the potential benefits of working with the private sector to provide high-quality HIV care for a significant proportion of the Namibian population. It also recognized the risk that a poorly trained private health sector might have nationwide repercussions by prescribing ineffective antiretroviral treatment, which may lead to the development of drug resistance.

Almost all clinical specialists work at least part-time in the private health sector. About 280,000 Namibians, or 17 percent of the total population, are covered by private medical insurance. This includes HIV treatment coverage for about 150,000 persons. Of these individuals, about 80 percent are beneficiaries of the Public Service Medical Aid Scheme (PSEMAS), the health insurance for government officials and their dependents, largely subsidized by the government.

Guidelines on clinical management of HIV/AIDS were released by the Ministry of Health in 2001, which included recommendations that only highly effective antiretroviral treatment (HAART) should be prescribed as this is the only treatment with durable effects. Despite this guidance, clinical specialists at the State Hospital in Windhoek received frequent reports about patients receiving ineffective ARV regimes. To remedy this situation and to ensure buy-in from the private sector, in September 2002 IMPACT/Namibia organized a consensus meeting with the main clinical specialists and general practitioners involved in HIV management and ART in Namibia. The report of this consensus meeting released in December 2002 formed the basis for the first draft of the Namibian national guidelines on antiretroviral treatment for the public and private health sector. After review of this draft, the guidelines were finalized in March, printed in April, and officially launched by the Minister of Health and Social Services in May 2003.

To promote the use of these guidelines and build local capacity and ownership for the treatment program, IMPACT/Namibia was instrumental in the establishment of the Namibian branch of the Southern African HIV Clinicians Society, who has become the main provider of training in HIV disease management for the private health sector, as well as the professional body representing both public and private practitioners in discussions and for promoting evidence-based, high-quality HIV care. The society, with support from IMPACT, facilitated the first lectures on ART and PMTCT in June 2003 in close coordination with the Ministry of Health and Social Services. The society was established as an independent local organization and is a member of the Southern African HIV Clinicians Society, which has branches in South Africa, Botswana, Zimbabwe, and Zambia. In April 2006 with support from IMPACT, the first Annual Congress was organized by the society. Furthermore, the society has been able to mobilize private funding from pharmaceutical companies to cover a large part of its training activities and operational costs.

Program Results

Program Outputs

IMPACT/Namibia produced the following deliverables:

Capacity building for materials development

- *TOT Peer Educator Manual, Peer Education Handbook with corresponding flipchart, and PMTCT Booklet*, developed in partnership with AIDS Care Trust, the Chamber of Mines, and the Walvis Bay and Sam Nujoma Multi-Purpose Centers; translated into Afrikaans and Oshindonga. The flipchart and handbook were revised in 2006 to include additional information on ART, OI, and TB treatment
- *Psychosocial Training of Trainers Curriculum*, developed through pilot training exercises with staff of Catholic AIDS Action, Philippi Namibia, and other FBOs, NGOs, and government line ministries. The curriculum was further adapted by Philippi Trust Namibia for use in its experiential learning camps for OVC under the title “Psychosocial Support Training for Group Leaders as well as a Psychosocial Training Manual for Caregivers;” CAA published a Namibia-specific version of a handbook by Sr. Silke-Andrea Mallmann of South Africa entitled, “Building Resiliency Among Children Affected by HIV/AIDS;” with support from FHI, this was translated into Afrikaans and Oshindonga for use in OVC psychosocial support programs.
- *Community Counselors Training Toolkit*, this toolkit was developed in collaboration with LifeLine/ChildLine and consists of six modules, each including a facilitator and participant manual. The Facilitator Guide introduces the entire training toolkit and contains information on the methodology, philosophy, and focus of the curriculum.
- *Standards-based Quality Improvement: a report from organizations working with OVC in Namibia*, a series of workshops with OVC stakeholders including children, resulted in the production of Namibia-specific outcomes and standards incorporating quality improvement for OVC services.

A complete list of BCC materials, reports, and publications can be found in Appendix II.

Program Outcomes and Impact

Capacity Building and Development

A vital component of the IMPACT/Namibia program was developing the capacity of local organizations—both government agencies and NGOs—to attain sustainable responses that impact the HIV/AIDS epidemic. Strong and lasting relationships based on mutual trust and respect form the foundation for capacity building activities that achieve tangible and measurable results. Participatory processes promote local ownership of and commitment to jointly defined goals and objectives. Subagreements serve as formal mechanisms for long-term capacity building and intensive exchange: they provide direction, clarity of task, transparency, and accountability on all ends.

With support from IMPACT/Namibia, local partners were able to effectively implement technical activities or deliver services within their focus areas. They have systems and processes in place that promote sustainable programs that will endure and expand. Most importantly, FHI’s

partners are able to *improve their performance*—offer better services, use resources more effectively, and achieve greater impact on the epidemic. IMPACT/Namibia offered technical assistance through workshops, coaching, and mentorship to implementing partners and various community organizations. By utilizing the skills and proficiencies both within its organization and among its partner agencies, FHI has been able to provide workshop training on a variety of topics ranging from strategic planning to ARV treatment. The overall purpose of capacity building was to ensure effective design, implementation, coordination, and management of wide-scale prevention, care and support efforts. IMPACT/Namibia staff assisted four partners, COLS, ELCIN, and the Sam Nujoma and Walvis Bay multipurpose centers to develop strategic plans for their organizations.

Training of Trainers

Capacity building did not end once new materials were produced. The IMPACT/Namibia team worked closely with the trainers from implementing partners to reinforce their understanding of new curricula developed, and to improve training and facilitation skills. From 2000 to 2006, TOT and refresher trainings were held for master trainers in peer education in the workplace, schools, churches and communities as well as working closely with trainers from LifeLine/ChildLine in piloting the six-module community counselor curriculum. This process also enabled master trainers to observe and provide technical support and feedback to facilitators, allowing them to develop their skills in this capacity as well as monitoring and supervision training. Periodic one-day refresher training was also conducted on topics such as treatment adherence, VCT, PMTCT, and associated topics for trainers and project managers. In addition, IMPACT/Namibia staff members were frequently involved in training programs conducted by other organizations including the Peace Corps and the US Embassy.

Behavior Change Communication

Youth

The goal of IMPACT/Namibia was to build the capacity of local organizations to develop, implement, and scale-up comprehensive prevention programs, including people affected by and infected with HIV. The youth programs emphasized communication skills and self-esteem, helping youth identify personal goals and develop both the values and the strength to say “NO,” empowerment and to assume responsibility for their behavior and health. Primary methods included peer education, participatory drama, plays, songs, publications by and for youth, and open discussions on reproductive health.

At the national level, IMPACT/Namibia supported the Reproductive Health page in the Namibian *YouthPaper*, a 12-page weekly insert in *The Namibian*, the only daily English-language newspaper in the country, to provide Namibian youth with up-to-date information on reproductive health, including HIV/AIDS. Through this dissemination vehicle an estimated 100,000 youth were reached weekly¹⁰ and close to one million copies of the *YouthPaper* distributed each year.

¹⁰ An ACNielsen survey conducted in 2001 among 2,809 people from across the country found that ten people read each copy of *The Namibian* every day. *The Namibian* sells 20,000 copies each day, in addition copies are sent 500 school libraries.

Of particular interest were the findings of a study conducted independently of this project by the Johns Hopkins Center for Communication Programs in partnership with the University of Namibia College of the Arts, that looked into HIV/AIDS, lifestyles, knowledge, attitudes, and practices of youth in the greater Windhoek area. The survey of 800 youth, ages 15 to 24 revealed that a majority of those reading newspapers had received information on HIV/AIDS from the *YouthPaper*. Most youth had never read *The Namibian* (93.3 percent), with the majority of those reading newspapers, stating they read the *YouthPaper* (71.4 percent) and *Open Talk*¹¹ (72.3 percent) inserts. For example, when asked where they learned about ways to prevent HIV, more than 60 percent of the respondents named the *YouthPaper* versus 45 percent citing *Open Talk*.

A second independent study was conducted by a visiting anthropology professor from Pacific Lutheran University, Tacoma, Washington, looking at “*Educating for Democracy: YouthPaper and Citizenship in Namibia.*” The study analyzed past issues of the *YouthPaper*, and conducted focus group discussions at selected schools in the north and Windhoek. Their overall conclusion was that the *YouthPaper* is well liked by teachers and learners alike and is used in the classroom as a teaching tool. From the interviews with students and teachers, the recurring theme was how the *YouthPaper* has helped students express themselves and identify themselves by certain characteristics. One respondent stated that the *YouthPaper* strives to engage youth in open discourse so that they will learn to “feel free” in their society and be involved in making positive social changes. The study also mentioned that the *YouthPaper* moved beyond basic information about HIV/AIDS to discussing various social, cultural, and epidemiological implications of HIV, such as the plight of AIDS orphans and PLHA.

The *LifeLine/ChildLine* school program, “Feeling YES, Feeling NO”, started in 1998, with European Union support, and subsequently funded and expanded by IMPACT. To date, the project has educated more than 90,000 third- and fourth-graders to improve their verbal communication skills through participatory drama and role-playing of their YES and NO feelings and how to deal with unwanted advances, touches, sexual, and other abuse. It provides the children with the necessary skills to respond, how to prevent it from happening, and where to go for help if it does. It also teaches children about HIV/AIDS before they become sexually active. During the IMPACT supported program, 567 teachers were trained to recognize abuse in children, so that they could be referred and receive in-depth therapy by professionals, including referrals for rape and attempted suicide. Under IMPACT/Namibia, the program expanded to 264 schools in all 13 regions of the country.

In 2005, in support of their school program, Lifeline/Childline launched their interactive weekly radio call-in magazine, *Uitani*, on Katutura Community Radio for and by young children (8 to 14 years old), supervised by trained adults. In the last year of the project, ChildLine expanded its program to reach-out to older youth through a new program called “Being A Teenager.” During the IMPACT period of support, 65,420 third- and fourth-graders were involved in the participatory drama program, and 7,658 youth were reached with the “Being a Teenager” program. In addition, 243 children were referred for professional long-term counseling and 1,085 vulnerable children participated in day camps. The radio program, supported by IMPACT and UNICEF, trained 42 youth in mass media, produced 256 spots, and reached an estimated 30,000 children through both its Saturday morning English language and Sunday morning local

¹¹ Open Talk, sponsored by the National Youth Council, another interactive youth-oriented insert in *The Namibian* focused on HIV and AIDS.

language programs via the National Radio-NBC. In support of this program, more than 95,000 educational materials were distributed.

Additional BCC activities involved the Ombetja Yehinga Organization (OYO), which specialized in the use of performing and visual arts to create social awareness among young people. Under its program focusing on three regions of the country, IMPACT/Namibia supported the program primarily in the Erongo region. The prime target group was in-school youth ages 12 to 25. The project was implemented in 46 schools where 539 teachers were trained, who, in turn, educated 6,487 learners on a variety of topics, including safe sex, reproductive health, including contraception, STIs, alcohol and drug abuse, stigma and discrimination, and promotion of counseling and testing for the sexually active. Through community-based theatre, the project reached more than 15,000 youth, and the project printed and distributed 2,000 copies each quarter of its OYO magazine (14,000 copies in total), written by and for youth. The program has continued with support from the Global Fund and the Dutch and French Cooperation, among others.

Over the course of the IMPACT/Namibia-funded program, 5,448 youth were reached with *Adventure Unlimited*—a scripture-based education and HIV-infection prevention program for children 9 to 13 years old; and 8,545 youth participated in *Stepping Stones*—a 14-session participatory education approach on relationships, gender, and communication for youth 13 years old and older; the latter provided discussion and activities regarding numerous contributing factors for unsafe sexual practices and practical skills to empower young people to make positive choices regarding their health and relationships. During the funding period, the program's regional staff increased from five full-time and two part-time YEP coordinators to 10 full time regional coordinators, responsible for the training of 477 peer educators and facilitators.

Despite the length of course interventions, there was very little attrition if the course was appropriately implemented using participatory learning techniques. Where there was high attrition, the regional YEP coordinator would target the peer educator and/or facilitator for more focused supervision and support. Close supervision revealed that where drop-out was higher the peer educator had reverted to more traditional didactic teaching methods, thus, losing the interest of the participants. Course evaluation revealed that most of the youth involved in the two programs showed improved understanding of the issues and the greatest area of improvement was in knowledge about HIV/AIDS and a better sense of self worth.

Under IMPACT, two youth-friendly multipurpose centers, located respectively in Walvis Bay and Ongwediva, provided services through a host of youth activities ranging from training in health and community outreach, use of drama and art for messages to youth, access to Internet, computer literacy, and after-school and/or school holiday programs.

At the WB MPC youth edutainment programs reached more than 13,000 learners in the Walvis Bay school district by using its 72 trained volunteers and people living with HIV/AIDS to convey messages on prevention, care, and support to learners and teachers through song, drama, and quizzes. The weeklong school holiday programs reached between 200 and 400 learners each year. A voluntary services overseas (VSO) information technology engineer from Canada, assigned to the centre, trained a local youth to manage the centre's computer training classes as well as basic computer and server maintenance. More than 500 youths have graduated from the

computer classes. The Ladies First community program used its six trained HIV-positive members to reach more than 8,500 community members in the high-density Kuisebmond area of Walvis Bay with prevention messages as well as community awareness about counseling and testing, PMTCT services, and ART treatment.

The Sam Nujoma Multi-purpose Centre attracted youth through its library and computer information center, and through its youth entertainment program by and for youth, including music, drama and sports, using themes that address societal problems such as drug and alcohol abuse, violence and rape, HIV and other diseases. The centre reached 7,711 learners in local primary and secondary schools with HIV/AIDS education and awareness activities, more than 25,539 people in the community and surrounding area through special information, education, and communication materials (IEC) events and awareness activities targeting various groups. The multipurpose center trained 164 people in peer and outreach health education.

Workplace Programs

In addition to the targeted youth programs, IMPACT/Namibia supported a comprehensive workplace program by building the capacity of local organizations to provide quality prevention and care programs. AIDS Care Trust, The Chamber of Mines, the multipurpose centres in Walvis Bay and Ongwediva, with the additional support of the AIDS Law Unit, targeted mainly the private, but also parastatal and government sectors of the country. Using the IMPACT/Namibia Peer Educator toolkit, they trained more than 1,100 peer educators in 62 companies, reaching on average 13,000 workers and their families each year of the project. In addition, they distributed more than 250,000 condoms over the life of the project. The Walvis Bay Multi-purpose Centre also worked in shebeens (informal bars) to reach members of the community during the evening. The trained health workers held weekly shebeen sessions throughout the year in the port area of the town and reached more than 2,000 bar clients each year.

The AIDS Law Unit of the Legal Assistance Centre was funded by IMPACT, to provide assistance to employers and trade unions in developing appropriate HIV/AIDS policies in the workplace. The development of these policies ensures access by people with HIV/AIDS to employment and employment benefits, and protects those already employed against stigma and discrimination. Policies are developed through a consultative process involving management, labor union, and employees through a series of meetings to ensure buy-in partner by management as well as to ensure that workers' needs are met and their interests protected. During the IMPACT funding period, the ALU assisted 43 companies, institutions, nongovernmental organizations, community- and faith-based organizations, and government ministries in formulating appropriate workplace policies, as well as reviewing and finalizing nine existing policies. In addition, the ALU conducted workshops on advocacy and rights of employees in support of the workplace program. It also represented, free of charge, employees who had been discriminated in the workplace because of their HIV status, tested without informed consent, and breach of confidentiality. It was instrumental in the revision of the new Labor Law, the National Code on HIV/AIDS and Employment, as well as in drafting and finalization of the National HIV Policy of the Government Republic of Namibia, approved by Cabinet on March 15, 2007.

Provision of Comprehensive Care and Support

Orphans and other children affected by HIV/AIDS

At the national level, IMPACT/Namibia supported the Ministry of Gender Equality and Child Welfare's (MGECW), (previously the Ministry of Women Affairs and Child Welfare) National Program for Action for Children, and the Permanent Task Force for OVC, which guides OVC programming in the country. The IMPACT/Namibia OVC strategy approved by USAID and the Ministry of Health and Social Services, Directorate of Developmental Social Welfare Services,¹² specifically supported strengthening an enabling environment at the national level, building the capacity of key stakeholders, and promoting access to quality care and support as well improved capacity for monitoring and evaluation. At the request of the Ministry, FHI supported an OVC technical advisor, seconded to the Ministry for the duration of the IMPACT program.

With support from IMPACT/Namibia, the AIDS Law Unit of the Legal Assistance Centre (LAC) assisted the MGECW through a series of meetings with stakeholders to develop the national policy on OVC. The objectives of the policy are to create a framework for protecting and promoting the wellbeing of all orphans and vulnerable children, to reduce the vulnerability of orphans to HIV infections, to ensure that OVC have nondiscriminatory access to education, to strengthen the multisectoral and multidisciplinary institutional framework, to coordinate and monitor the provisions of services to OVC, and to provide access by caregivers to advice and information on their rights and entitlements under social security and welfare legislation. The policy was approved by Parliament in December 2004, and was officially launched by the President of the Republic of Namibia at the third National OVC Conference in February 2005. Five thousand copies of the policy were printed in six languages and distributed nationwide.

The Government of Namibia, through the MGECW and with support from the LAC, has enacted important pieces of legislation including the Combating of Domestic Violence Act and the Children's Maintenance Act (2003); and the Children's Status Act (January 2007). The draft Child Care and Protection Act to replace the existing Children's Act of 1960 addresses issues such as adoption, primary care taker, children with special needs, as well as rights of inheritance between father and child.

After the enactment of the Children's Maintenance Act, the FHI OVC technical advisor and colleagues at the MGECW developed a brochure on child welfare grants. The leaflet specifies the four types of grants available: maintenance grants, special maintenance grants for children under 16 with disabilities; foster care grants and place of safety allowance. It also explains who qualifies, what documents are required, and where to apply for the grant. With support from IMPACT/Namibia, the brochure was translated and printed in six languages and distributed during trainings in all 13 regions. The Government of Namibia, through its line ministries, increased monthly child welfare grants from less than 7,000 recipients in 2003 to more than 53,000 recipients by September 2006.

¹² Division of Child Welfare, originally within the MoHSS, was moved to the newly established Ministry of Women Affairs and Child Welfare (MWACW), which changed its name in 2005 to the Ministry of Gender Equality and Child Welfare (MGECW)

IMPACT/Namibia, through its OVC technical advisor, provided assistance to the MGECW to revise the National Plan of Action for Children, a plan that stipulated how best to support OVC in Namibia. In addition to providing technical input, the OVC/TA assisted the Ministry to coordinate subcommittee meetings, confer with key stakeholders, and highlight OVC strategies that other countries were implementing. On August 1, 2002, the Ministry re-launched the revised National Plan of Action, replacing the original that was put in place in 1990 after the Government of Namibia signed the Convention for the Rights of the Child.

Subsequently, under the guidance of the Permanent Task Force for OVC (PTF/OVC)¹³ with the support of the OVC/TA, a local consultant hired by UNICEF conducted a Rapid Assessment, Analysis, and Action Plan (RAAAP), which served as the basis for the current National Plan of Action 2004 to 2010. To complement and reinforce the National Plan of Action, the PTF/OVC hosted a series of meetings for the development of a National Monitoring and Evaluation Plan. In April 2006, a final stakeholders' workshop funded by UNICEF and facilitated by FHI, resulted in the final draft of the National monitoring and evaluation (M&E) plan and its subsequent approval by the Ministry.

At the regional and community level, the IMPACT/Namibia project focused on expanding educational development opportunities for OVC and developing community and faith-based support systems. Special emphasis was placed on psychosocial support of OVC through experiential learning camps, after-school programs, and home visitation by specially trained home-based care volunteers.

Based on the success of a pilot program under IMPACT/Namibia's small grant program providing support to 100 needy children in Windhoek, CAA developed the Schooled for Success program to expand its work with communities to ensure that OVC succeed in school. The project promoted full school participation for identified orphaned and vulnerable children with an emphasis on increasing educational opportunities for girls; the expanded program used trained volunteers and a school voucher system. CAA also educated community leaders, volunteers, and caregivers about the rights of all children to attend school. In addition, CAA leveraged funds from the private sector and individuals to ensure that OVC received blankets and food packages as Christmas and/or Easter gifts with more than 2,000 OVC benefiting initially from the program in the three regions served by IMPACT/Namibia. To facilitate access to uniforms and school supplies, CAA signed an agreement with post-exposure prophylaxis (PEP) (a national supply store) ensuring that CAA vouchers were accepted at all PEP stores country-wide, thereby facilitating distribution and record-keeping of school supplies and uniforms. In addition, PEP stores gave CAA a 10 percent discount on all supplies procured through the voucher system. Under PEPFAR, Schooled for Success evolved into the largest component of the OVC program, expanding through CAA's 14 regional offices in nine political regions of the country.

Home-based care providers were trained to identify OVC in greatest need and to provide psychosocial and supplemental support in the local community setting. The majority of CAA's 1,500 active volunteers were trained in building resiliency in children affected by AIDS and

¹³ Previously the National Steering Committee for OVC

HIV¹⁴. Nationwide, the neediest OVC registered with CAA were provided with educational assistance, ranging from school uniforms, school supplies, school fees (if not waived) and other material support. Over the course of the program, a total of 27,575 OVC received school uniforms and supplies enabling them to attend school with pride and dignity. IMPACT/Namibia staff also leveraged private donations to administer two privately funded scholarship programs with CAA, providing complete school expenses for more than 300 “best and brightest” secondary school students. IMPACT/Namibia and CAA staff and volunteers assess those children who have the greatest potential to succeed in further education, but are in need of scholarship funding and support. This “Saving Remnant” scholarship program has graduated six OVC who are now attending tertiary educational institutions.

Eight after-school programs provided regular support for at least 1,500 children. Eight emergency feeding programs provided services for at least 1,000 children per month. Through a partnership between the Ministry of Gender Equality, CAA, and the World Food Programme, 58,000 OVC in northern Namibia received food in 2006.

To ensure consistent training across all organizations providing support to children, CAA worked alongside Philippi Trust to develop and field-test a psychosocial TOT curriculum. With support from IMPACT/Namibia, CAA and Philippi staff participated in psychosocial support training in Zimbabwe, and used their newly acquired expertise to develop a Namibian psychosocial support curriculum and training program for home-based care volunteers and teachers in Namibia. The psychosocial training program greatly increased the capacity of stakeholders to provide psychosocial support for OVC, including best practices on how to deliver psychosocial support for OVC. The manual was translated into Oshindonga and Afrikaans to facilitate training of the volunteers, most of whom do not have a good command of the English language. This manual was later revised and adapted by Philippi Namibia for use in their experiential learning camps and kids clubs.

Philippi Namibia, with the experience gained in working with CAA to develop their psychosocial curriculum and training, embarked on an expanded support program for OVC. With support from IMPACT/Namibia and the BMS “Secure the Future” program, Philippi Namibia increased the wellbeing of OVC by building the capacity of church and NGO-affiliated youth to provide psychosocial support to OVC.



Graduates of joint training between Philippi & CAA (photo courtesy of Philippi)

They used learner-centered training modules consisting of two phases: “Listening and Responding Skills” trains young people to listen and know how to

¹⁴ The projects/programs that incorporate the psychosocial needs of children had often received their training from Catholic Aids Action’s “Building Resilience in Children” course. Study funded by UNICEF “ Who works, who pays and who decides”, 18 March 2006, unpublished

respond to peers and to assess leadership skills. Youth who passed the first phase qualify to continue to the second phase. The second phase is geared towards counseling the child and helping the child to overcome difficulties and fears through experiential learning.

Upon graduation, the trained youth, called group leaders, and Philippi staff conduct week-long experiential learning camps for OVC, ages 8 to 18, as well as kids' clubs, enhancing OVC's coping skills in dealing with challenging and stressful life issues. Philippi trained 498 caregivers in psychosocial support, approximately 1,000 OVC benefited from the camps, and selected group leaders supported more than 2,200 OVC through 14 kids clubs in their communities.

The AIDS Law Unit, in addition to its support at the national level, worked closely with other AIDS services organizations in Namibia, in support of their OVC programs. They provided training to the IMPACT implementing partners' staff and volunteers on inheritance, writing wills, basic rights, and access to benefits and entitlements.

With the advent of PEPFAR funding, IMPACT/Namibia was also able to scale up and expand its OVC program through additional support to Christian and faith-based organizations that play a crucial role in supporting OVC within their communities.

The Church Alliance for Orphans (CAFO) as an umbrella organization, mobilized, intensified, and strengthened the response of local congregations irrespective of denomination, through the implementation of community-based programs to help the OVC grow up in a safer environment.



Dr. Platt, CAFO, World AIDS Day 2006, at the White House, being honored by President Bush for receiving a grant totaling US\$1 Million under the PEPFAR New Partners Initiative (NPI)

They primarily worked in areas where other FBOs were not represented through their 62-member committees and 341 trained volunteers. CAFO built the capacity of each committee's local members to provide a holistic service to OVC in their community by sensitizing, mobilizing, and the strengthening of community-based responses through member churches. Interventions included advocacy and psychosocial support training, as well as the disbursement of small grants for income-generation projects and other necessities for the OVC, successfully reaching more than 5,000 OVC. With technical support from FHI/Namibia, CAFO applied for and received US\$1 million under the PEPFAR NPI in support of their OVC program.

The Lutheran Churches in Namibia with their network of close to 300 congregations and an army of church volunteers and pastors provided support within their communities. The Evangelical Lutheran Church in Namibia AIDS Action, supported OVC through its pastors and church volunteers. These volunteers monitored OVC within their congregations to ensure that

they were not discriminated against and were provided with psychosocial support and assistance from the community to attend school. With support from IMPACT/Namibia, ELCIN AIDS Action developed an OVC strategy to identify effective options from which parishes or communities could select to care for OVC in their communities. The strategy consists of five focus areas: registration of OVC with the Ministry of Gender Equality and Child Welfare; provision of training on psychosocial support; collections of money and/or food in parishes for those in need; use of donated land for agriculture projects; and a microfinance project for OVC caregivers in partnership with Project HOPE.

Following the development of this strategy, ELCIN AIDS Action asked each parish to identify an OVC focal person to be responsible for information and training. A three-day advocacy and training workshop for these parish-based OVC focal people was held in November 2005, with more than 110 participants. The intention was for the focal people to assist their communities to identify OVC in need and to suggest a comprehensive way for their particular community to move forward. ELCIN registered over 37,000 OVC using the MGECW registration form in support of the National OVC database, as well as for the MGECW/World Food Programme OVC Food Support Program.

The Evangelical Lutheran Church in the Republic of Namibia AIDS Program worked mainly in the south and west of the country, supporting more than 1,500 OVC with school uniforms and after-school programs, and psychosocial support with special attention toward addressing the particular needs of vulnerable girls. ELCAP also refers families in need to government social workers or to CAA's Orphans' Emergency Fund.

TKMOAMS (Oshiwambo acronym meaning: "All mighty father help us stop the AIDS pandemic in the country") is a grassroots project started by volunteers based at the Oshakati hospital, provides home-based care and OVC support to families throughout the four northern regions of Namibia. TKMOAMS was initially supported through a rapid response fund for a school uniform sewing project that provided much needed uniforms for OVC. IMPACT/Namibia's expanded support concentrated on developing TKMOAMS managerial and supervisory skills' building as well as technical skills and training to improve the wellbeing of OVC through psychosocial support. Pictorial OVC reporting forms were developed in collaboration with TKMOAMS using the FHI OVC Toolkit and volunteers were trained on how to use the forms. With the support of IMPACT/Namibia and the Danish-funded Yelula program, TKMOAMS became a registered NGO with a board of directors and its own offices built with EU funding. By the end of the project, TKMOAMS was operating in 38 communities, providing psychosocial care and support to more than 700 OVC. The school uniform sewing project distributed uniforms to 321 boys and 1,170 girls, and soup kitchens in six communities provided more than 800 OVC with meals three times a week. Additionally, the agricultural food project supported 10 fields to grow maize and other foods for the communities' PLHA and OVC.

The Sam Nujoma MPC as part of an overall community outreach and support program, and with funding from IMPACT, supported 140 OVC through a daily after-school program that provided children with a meal, supervised homework, play and games, as well as psychosocial support as needed by a VSO volunteer, who in turn trained local volunteers in caregiving and support.

In the last year of the IMPACT program, the Rhenish and Apostolic Faith Mission (AFM) churches were added to the program under the emergency plan. The Rhenish Church received support for its budding OVC program in six rural congregations in the underserved farm communities in the south. The newly established project worked closely with CAA and CAFO for training and support. The project registered 95 OVC and 60 were supported with school uniforms. Thirty-five children were taken on a weekend camp, and 65 children were educated in the UNICEF supported Window of Hope program. An additional 98 children were reached through visits to Sunday schools by the OVC coordinator.



AFM community in the South, photo courtesy of Lucy Steinitz

AFM supported 479 households, where they provided psychosocial and nutritional support, as well as information on legal rights and social grants. The AFM Hope Club in Grootfontein has 72 OVC, meeting twice a week, and are provided with food, supervised play and psychosocial support. A total of 1,790 OVC were served by the AFMAA. AFMAA staff and volunteers also provided AB education to more than 11,000 people in their community.

HOME-BASED CARE AND SUPPORT

Early in the course of the HIV/AIDS pandemic in Namibia, end-stage disease occurred infrequently and could be handled with long hospital stays, much like other terminal illnesses. As the pandemic matured, however, the number of sick people rose exponentially and quickly overwhelmed the existing healthcare resources. The demand for hospital beds often outnumbered the supply. Thus, while PLHA may be hospitalized several times during the course of their illness with intervening periods of relatively good health, end-stage disease has become primarily a family and community responsibility.

Before the advent of widespread treatment for PLHA, quality home-based care (HBC) was the only support available to most HIV patients facing illness and ultimate decline. In Namibia, the provision of HBC through trained volunteers started in the mid-1990s, and spread rapidly with the founding of CAA in early 1998.

Most HBC volunteers are women living in rural communities, and engaged in subsistence-agriculture, but are not formally employed. Typically, the volunteers can read and write at primary-school level, but only in their local language. Recruitment efforts were instigated to attract younger volunteers and men as HBC providers. An internal study by Namibian Resource Consultants¹⁵ ascertained why HBC volunteers chose to get involved and remain affiliated with Catholic AIDS Action. Examples of answers received included: “I see that my neighbors are sick

¹⁵ Catholic AIDS Action: Organisational Review and Strategic Plan. Windhoek, Namibia, 2002 Unpublished.

and many children have become orphaned, and I want to help them;” and “It is my Christian duty to follow the teachings of the church, including the example of Jesus.”

Although IMPACT/Namibia worked with HBC volunteers in support of its OVC program, it was not until it received PEPFAR funds that it expanded its support to include community outreach and HBC through faith-based and community organizations as part of its integrated approach to counseling and testing, PMTCT, and ART treatment. Under this expanded program, and working very closely with CAA for training, other FBOs were added to provide care and support in their communities.

HBC volunteers provide counseling and emotional or spiritual support, practical assistance with household chores such as cooking and cleaning, encouragement to live positively through good nutrition with locally available foods, talking openly about one’s HIV status, and preventing the further spread of HIV. Referrals for medical intervention are made in conjunction with local church and government health institutions. HBC volunteers receive 84 hours of training and education, are supervised on a monthly basis by CAA staff, and receive regular refresher training. With the advent of ART, clients who live within the catchment area of 1 of the 34 district hospital have access to treatment, and as a result, their health is improving and they are able to resume a normal life. The HBC volunteer’s duty then shifts to become a treatment supporter.

ELCIN AIDS Action engaged their church and traditional leaders for community mobilization in support of people infected and affected by HIV/AIDS. The ELCIN AIDS Action Program used its pastors and church members in 70 parish-based HBC groups providing home based care to community members. More than 600 active volunteers provided care for an average of 6,500 clients during the last year of the project, which demonstrates the significant amount of care as well as the serious need for care that is present in the community. In addition to training parish- and community-based volunteers, ELCIN partnered with CAA and the AFM AIDS Action to conduct Namibia’s first interagency Oshindonga-language TOT for HBC and counseling, and graduated 23 trainers from the three organizations.

The presence of ELCIN chaplains at the Oshakati District and the Onandjokwe Lutheran Hospitals provided an excellent opportunity for on-site referrals and follow-up for patients who seek services at these facilities. The chaplains also facilitated support groups for PLHA and widows within the hospital facilities. In addition, many of the volunteers had good relationships with the clinics and health centers in their areas, and frequently, patients were accompanied by their HBC provider when they sought medical treatment at a local facility. In terms of referrals for VCT, ELCIN AIDS Action had established an excellent relationship with the CAA-Oshakati New Start VCT centre, as well as its own Eenhana New Start Centre supported by the Global Fund for referral of clients and community members.

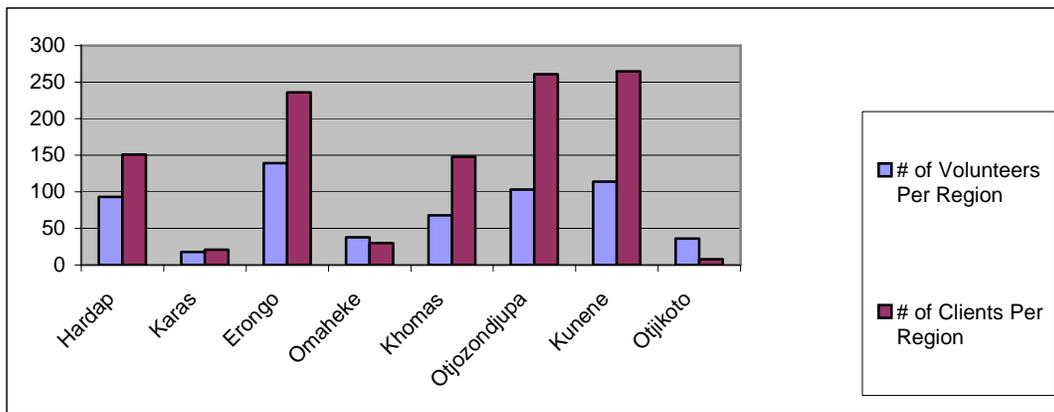
ELCIN AIDS Action reached out to traditional leaders and jointly conducted 11 community HIV/AIDS education conferences with traditional leaders across northern Namibia. Issues addressed at these events include the importance of knowing one’s HIV status, prevention of PMTCT, how antiretroviral treatment works and where it can be accessed, care and support for people living with or affected by HIV/AIDS, the influence of alcohol on HIV transmission, and the need to break the silence caused by stigma and end discrimination against people with

HIV/AIDS. Through these community education conferences, nearly 10,000 people were reached in 2004, more than 21,000 during 2005 and nearly 1,000 community members at the single event held in 2006.

ELCAP operated in eight regions of Namibia, providing HBC services in 67 towns and settlements through its 609 active church and community volunteers. ELCAP worked closely with CAA to train 10 master trainers, who in turn trained the ELCAP HBC volunteers, which provided services to 1,120 clients and their families in the last year of the project. In addition, ELCAP staff and volunteers conducted community outreach for PMTCT, VCT, and ART from their head and four regional offices; three of the regional offices also operate New Start VCT centres, two of which were renovated with support of IMPACT/Namibia.

Challenges have been experienced at ELCAP due to a lack of direct funds for activities and pastor turnover, which is a system whereby most pastors in the ELCRN church rotate every three years, thus, breaking continuity at parish level. This is why deacons—not pastors—now take charge at the congregational level.

Number of Volunteers and Clients Served by ELCAP per Region



The Apostolic Faith Mission AIDS Program was supported in the last year of IMPACT/Namibia, and operates mainly in the maize-belt around Grootfontein. After three of its staff participated in the joint CAA, ELCIN and AFM TOT training, the project trained 115 volunteers. As of June 2006, 100 were still active and provided HIV-related palliative care through 16 service outlets to 716 individuals living with AIDS.

The 38 groups of community-based volunteers affiliated with TKMOAMS provided care and support to more than 800 households per month. Unlike many other partners, they began in 1996 as a grassroots entity, with groups of women and a few men across four regions of northern Namibia visiting their neighbors and providing household assistance. As they gained more training, these volunteers took on additional duties involving hands-on care. Deeply embedded in their local culture and traditions, TKMOAMS is one of the most sustainable programs in Namibia, according to a field assessment in 2006 by FHI staff.

Comprehensive Integrated Services for Prevention, Care, and Treatment

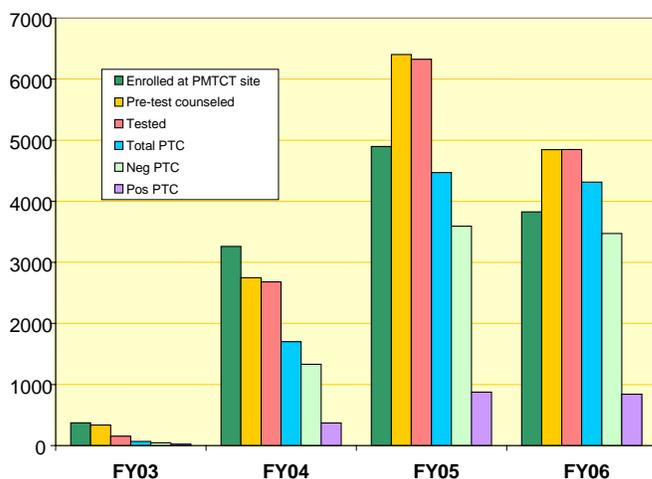
The integrated services for prevention, care, and treatment comprised the largest program under the PEPFAR in terms of funding, infrastructure building, and reach, and were supported at the five faith-based hospitals, serving the mostly very rural areas of Namibia. Services included PMTCT, CT, and HIV treatment, including ART services for pregnant women.

Prevention of Mother-to-Child Transmission

From 2000 to 2006, a total of 11,984 women were enrolled in PMTCT programs at their first antenatal care visit at the five PMTCT sites supported by IMPACT/Namibia. In addition, many women initially enrolled in other district ANC health facilities went for CT at the hospitals later in their pregnancy. A total of 13,995 pregnant women were pretest-counseled, and of these, 13,852 (99 percent) were tested for HIV. Of these women, 10,485 (76 percent) were post-test-counseled and received their results, of which 2,087, or 20 percent, tested HIV-positive.

The number of pregnant women who were counseled, tested, and received their HIV status increased from 264 during the first quarter of the PMTCT program (October to December 2003) to 1,472 during the last quarter of the program (April to June 2006). This increase was the result of a combination of changes that were introduced over time: routine (“opt-out”) CT, same-day rapid testing, rapid testing at the labor ward, and outreach of CT to peripheral district health centers.

Counseling and Testing for PMTCT during Antenatal Care (ANC)					
	FY03	FY04	FY05	FY06	Total
Enrolled at PMTCT site	371	3,262	4,896	3,826	12,355
Pretest counseled	336	2,747	6,402	4,846	14,331
Tested	154	2,679	6,325	4,848	14,006
Total post-test counseled	67	1,702	4,470	4,313	10,552
Negative post-test counseled	44	1,332	3,594	3,472	8,442
Positive post-test counseled	23	370	876	841	2,110



Overall acceptance by pregnant women of HIV testing was very high. This is illustrated by the fact that many pregnant women who enrolled at antenatal clinics which did not offer PMTCT services went to the PMTCT sites for counseling and HIV testing later in pregnancy. This explains why the number of women receiving PMTCT services was 17 percent higher than the number of pregnant women enrolled at PMTCT sites for their first ANC visit.

A total of 18,673 women delivered at the five hospitals from October 2003 to June 2006. A total of 2,222 women with known HIV-positive status delivered at the hospital. Of these positive women, 2,004 (88 percent) received ARVs before delivery, of which 1,717 (86 percent) received Nevirapine; 78 (4 percent) received Nevirapine and AZT; and 209 (10 percent) received HAART. Only 299 women did not receive treatment, probably because many of them arrived late in labor at the hospital and their status was only known after delivery. For a total of 2,172 (91 percent) of the HIV-exposed children of known positive mothers it was reported that these received Nevirapine after birth. All women were counseled on infant feeding options. Most HIV-positive mothers (88 percent) chose to breastfeed exclusively.. Only 281 mothers (12 percent) chose to give exclusive replacement feeding.

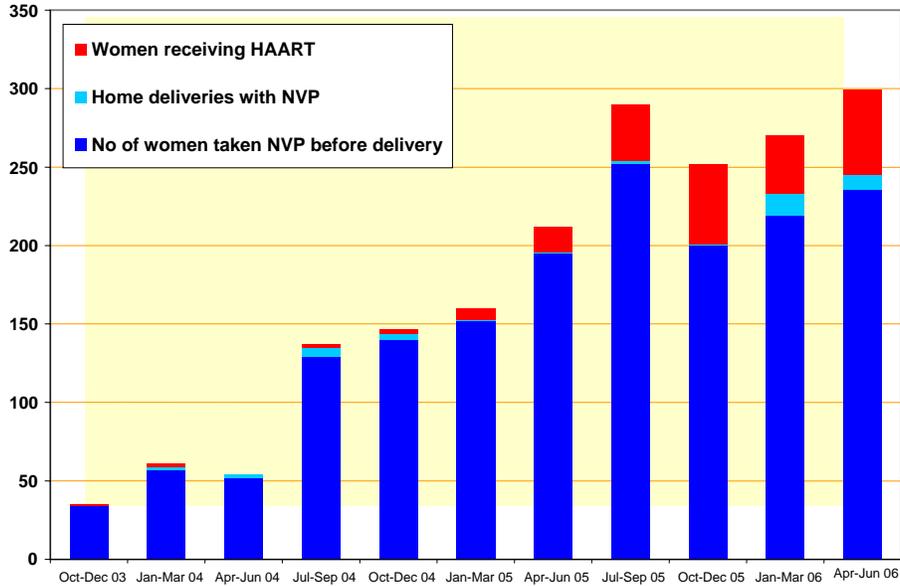
Antiretroviral Treatment for Prevention of Mother-to-Child Transmission					
Deliveries	FY03	FY04	FY05	FY06	Total
Total deliveries		6,484	6,881	5,308	18,673
Known status at delivery		n/a	3,234	4,589	7,823
Known HIV-positive at delivery	9	315	901	997	2,222
Received NVP	9	282	747	679	1,717
Received HAART	0	5	62	142	209
Other ART	0	0	22	56	78
Total mothers ART	9	287	831	877	2,004
Infants receiving NVP	9	287	887	1,001	2,184

The percentage of mothers who delivered at the hospitals and knew their HIV status before or just after delivery increased from 68 percent during April to June 2005 to 91 percent during the same period in 2006. Of the 353 HIV-positive women who delivered during the last quarter of the project, 90 percent received ART for PMTCT and all 353 children delivered by HIV-positive mothers received Nevirapine at birth. This illustrates the high acceptance of HIV testing and efficiency of the PMTCT services at the five mission hospitals at the end of the project.

Combined ART and, in particular, HAART, is much more effective in reducing MTCT of HIV than single dose Nevirapine. Starting HAART during pregnancy for women who qualify for ART according to the national guidelines (WHO stage 3 or 4 disease or CD4<250 cells/ml) therefore contributes significantly to PMTCT, increasing the life expectancy of the mother. This reduces the risk for maternal mortality and improves the health of the mother and the life expectancy of her children. Efficient enrollment of HIV-positive mothers into the HAART program was therefore a priority component of the IMPACT/Namibia PMTCT program.

Increased enrollment was achieved by the introduction of rapid testing, routine referral of HIV-positive mothers for CD4 testing, improved efficiency of laboratory services and routine referral for clinical staging and ART enrollment for pregnant women qualifying for treatment, which accounted for 16 percent of PMTCT regimens in the last quarter of the project. The combination of improved knowledge of serostatus at delivery and increased use of more efficient regimens resulted in increased impact of the program to prevent HIV infections in infants during the course of the project.

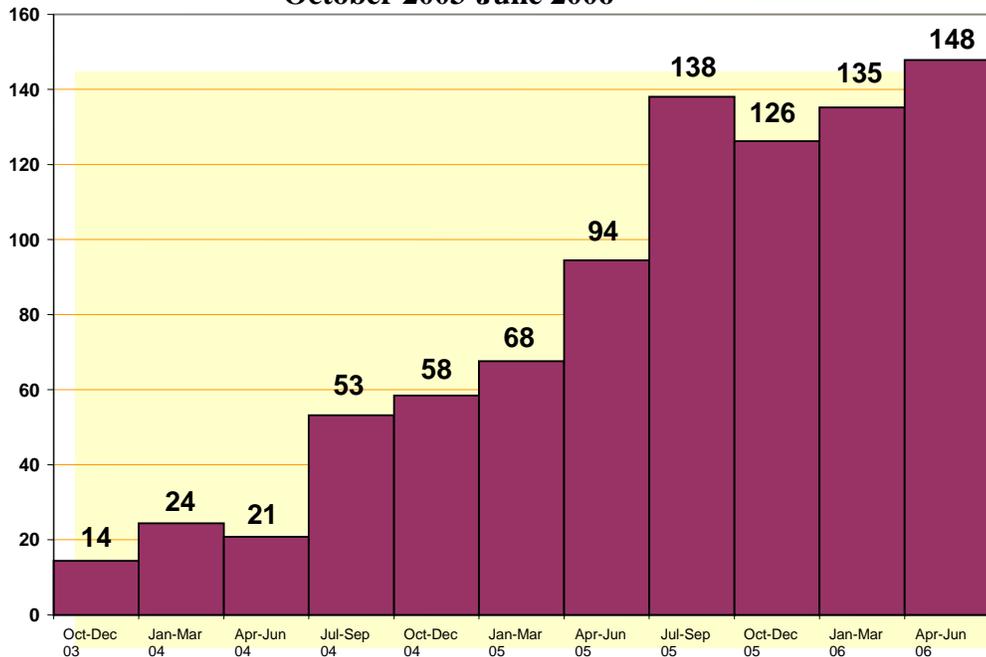
**PMTCT Services Received By Women Enrolled
5 Mission Hospitals, Namibia, Oct 2003 - Jun 2006**



Impact of the PMTCT Program

Nevirapine (NVP) for the mother and the child reduces MTCT of HIV by 41 percent in a predominantly breastfeeding population. Assuming 60 percent effectiveness for AZT plus NVP and 80 percent for HAART, a total of 880 HIV infections in infants were prevented over the life of the project.

**Estimated number of HIV infections prevented at 5 Mission Hospitals
October 2003-June 2006**



Counseling and Testing

IMPACT/Namibia supported “New Start” counseling and testing at three CHS hospitals and the two stand-alone VCT centers, the Walvis Bay Multi-purpose Centre and the New Start VCT center in Rehoboth in collaboration with PSI/SMA. At the CHS and LMS hospital, PMTCT provider initiated (“diagnostic”) counseling and client initiated (VCT) counseling services were provided. At the Walvis Bay and Rehoboth VCT centers, only client-initiated services were provided. PMTCT counseling is reported separately above. Under this section all other counseling and testing is reported.

A total of 19,139 clients were counseled and tested during the entire period of the project (September 2003 to June 2006).

<i>Number of clients counseled and tested, and received their results at New Start VCT Centers supported by IMPACT, September 2003 to June 2006</i>					
	FY03	FY 04	FY05	FY06	Total
Andara		196	635	755	1,586
Nyangana		192	757	833	1,782
Oshikuku	1	839	2,852	2,944	6,636
Rehoboth		478	843	900	2,221
Walvis Bay	28	1,000	2,693	3,193	6,914
Total	29	2,705	7,780	8,625	19,139

At the LMS Onandjokwe hospital, in support of PMTCT services, CT was provided for ANC clients. In addition, a local CBO based on the hospital grounds, the Katonyala Project provided pre- and post test counseling for VCT. During the last year of the project, more than 10,000 clients were counseled and tested through Katonyala.

To improve service delivery, including rapid testing, better oversight, and data capturing and analysis through a computerized system, LMS decided to integrate VCT into the centre as well. IMPACT/Namibia provided funds to expand the centre to be able to provide CT to all clients seeking services. Additional rooms and offices were added to the existing building to provide confidential space for counseling, including routine HIV testing and management of TB patients. The expansion was completed in October 2006, and CT, ANC, PMTCT, ART, and TB services can therefore be provided at one integrated facility.

According to the 12-month data for the period July 2005 to June 2006, the percentage testing positive was higher in hospital-based centers (range 36 to 45 percent) than for stand-alone centers (range 5 to 20 percent). This is mainly due to the high number of symptomatic clients that are referred at hospitals for diagnostic purposes.

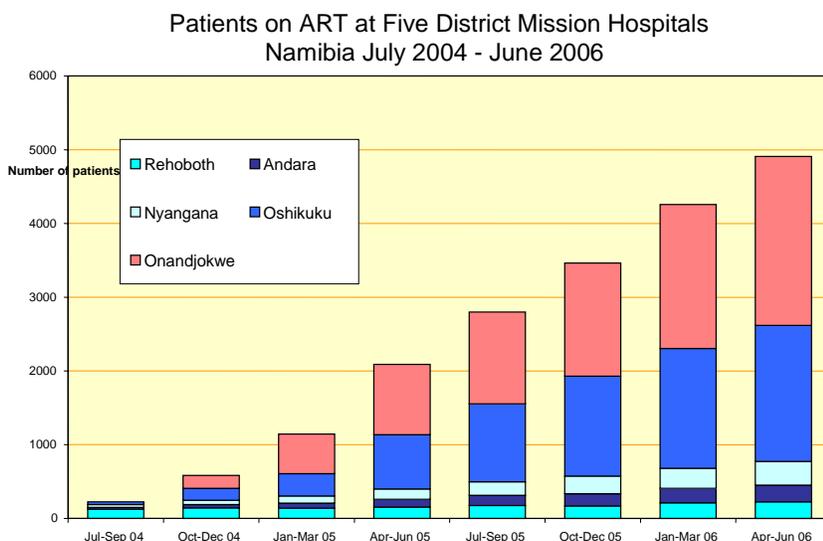
From the end of 2003 through June 2006, LifeLine/ChildLine trained community counselors for both the Ministry of Health and Social Services and FBO/NGOs funded under the PEPFAR. With support from IMPACT/Namibia, LifeLine/ChildLine’s training capacity was increased from one dedicated trainer in 2003 to a team of two master and four regular trainers. Part-time and consultant-trainers trained more than 500 community counselors using the Community

Counselors Training Toolkit, developed and field-tested with technical assistance from IMPACT/Namibia.

Antiretroviral treatment

By August 2004, PEPFAR had made antiretroviral treatment available at all four CHS hospitals, and by November 2004, the Lutheran Hospital in Onandjokwe began to provide ART services through its integrated centre, “SHANAMUTANGO,” to the more than 1,000 patients on the ART waiting list.

By the end of June 2006, a total of 5,406 treatment patients had been assessed and enrolled at the five faith-based hospitals. In addition, 412 patients were referred from other hospitals, bringing the total number of ART patients enrolled over the life of the project to 5,818. Of those, 4,909 patients were still on treatment by June 2006.



Treatment uptake increased rapidly during the first half of calendar year 2005, with the uptake of patients that had been assessed previously and on the waiting list as well as patients transferred from other hospitals (mainly Oshakati). Enrollment of new patients stabilized at approximately 300 per month for the five hospitals combined.

ART started at Mission Hospitals by Fiscal Year

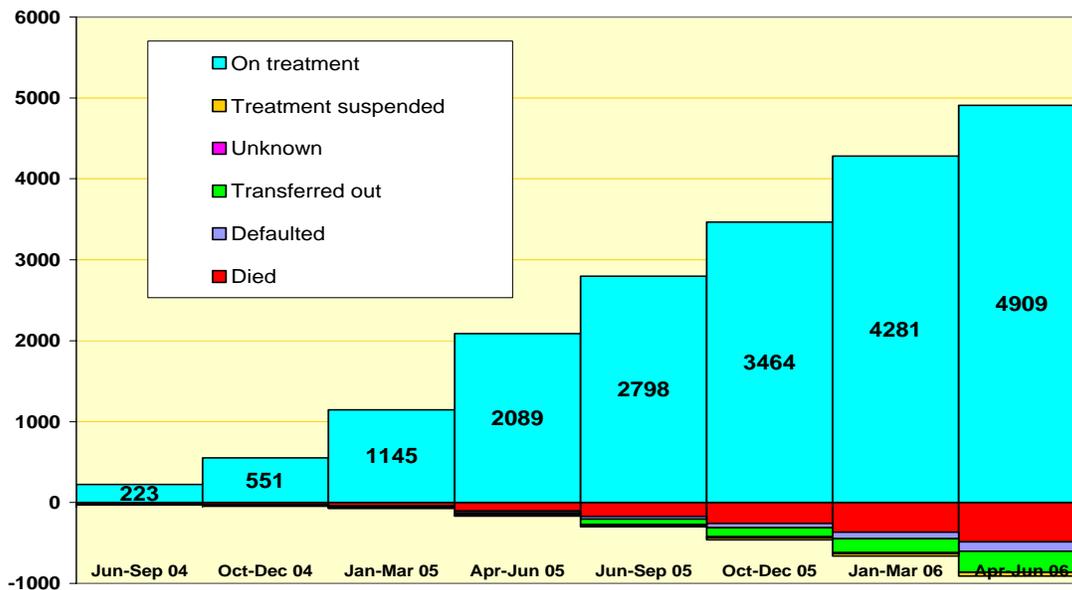
Started treatment	Andara	Nyangana	Oshikuku	Rehoboth	Onandjokwe	Total
FY04	23	39	35	127	0	224
FY05	135	162	1,078	93	1,154	2,622
FY06	129	177	961	82	1,211	2,560
Total	287	378	2,074	302	2,365	5,406

On treatment	Andara	Nyangana	Oshikuku	Rehoboth	Onandjokwe	Total
FY04	23	39	35	127	0	224
FY05	139	183	1,056	176	1,245	2,799
FY06	227	321	1,845	226	2,290	4,909

Treatment outcome

Of the 5,818 patients that were ever enrolled at any of the five hospitals, 4 percent were transferred to other ART sites, usually due to change of residence. Of the remaining 5,563 patients, 4,909 (88.2 percent) were still on treatment by the end of June 2006. Of these, 1,013 (21 percent) were children less than 13 years of age. A total of 485 (8.7 percent) patients had died, 125 (2.2 percent) defaulted, and treatment was suspended for 56 (1 percent) patients. For four patients only (0.1 percent), was their status unknown at the end of June 2006 and therefore were classified as “lost for follow-up.”

Outcome of Antiretroviral Treatment in 5 mission hospitals, Namibia July 2004 - June 2006



Treatment Regimens

Information on the treatment used was available for all of the 4,909 patients. The most commonly used treatment regimen for adults are the recommended first line regimen of d4T/3TC/NVP (57 percent), d4T/3TC/EFV (28 percent) and AZT/3TC/NVP (11 percent). Only 10 (0.2 percent) of patients were receiving PI-based regimens, of which only four are second-line ddI containing regimens. A total of 20 patients received other regimens. Most of these regimens contained Tenofovir for indications of HBV co-infection, lactic acidosis, or severe peripheral neuropathy.

Among the 1,013 (21 percent) children under 13 years, 496 (73 percent) received AZT/3TC/NVP, 11 percent d4T/3TC/NVP, 10 percent AZT/3TC/EFV, 3 percent d4T/3TC/EFV. Only two patients (0.3 percent) received d4T/3TC/LPV-r. The remaining 15 patients (2 percent) received other regimens.

Non-ART Clinical Care for PLHA

Annually, there are more than 35,000 hospitalizations of adults and children at the five IMPACT-supported mission hospitals, according to the MoHSS Health Information Systems Report. Of these hospitalizations, about 2,500 were recorded as HIV-related, of which about 700 were diagnosed as HIV and TB co-infection.

Specific efforts were made to promote routine testing for all patients with symptoms that might be HIV-related; in particular patients, with TB of which about 60 percent were expected to be HIV-infected according to a survey conducted in 1998 and standard operating procedures were established to ensure that all hospitalized patients diagnosed with HIV were clinically staged, adequately managed, and enrolled for ART according to the eligibility criteria.

Training in the management of opportunistic infections was organized by the Ministry of Health for all clinicians managing HIV with support from Centers for Disease Control and Prevention (CDC)/ITECH. IMPACT/Namibia contributed to the facilitation of these trainings and assisted in building the capacity of the local clinicians at LMS and CHS to take up the facilitators' role, thus enabling CHS and LMS to conduct training on HIV management and ART at the national and district level. In addition, the mission hospitals organized in-service training for district staff in managing opportunistic infections and ART.

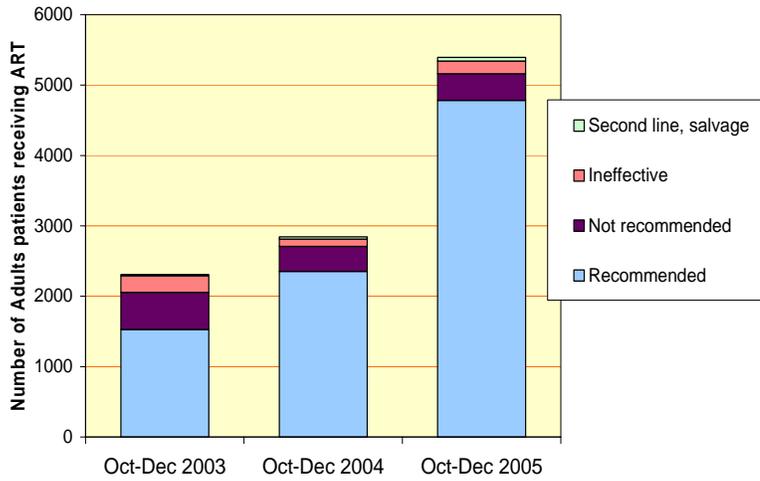
ART in the Private Health Sector

A total of more than 280,000 Namibians (17 percent of the population) are covered by private medical insurance. Most of the insurance policies cover ART and some provide managed care programs for HIV. IMPACT built the capacity of local organizations with support from PEPFAR to improve access and quality of care and has been compiling information from the private sector since 2003 to monitor the coverage and quality of ART and give feedback to stakeholders. Through the established good relations with the private health sector, FHI gained access to different sources of information on dispensing of ARVs in the private sector between 2003 and 2005.

ARV-dispensing data from medical insurance companies, and data from online insurance claims from all private pharmacies were compiled and analyzed for the last quarters of 2003, 2004, and 2005. ART regimens were compared with national and international guidelines and classified into recommended (NNRTI-based and boosted PI-based), not recommended (non-boosted PI-based or d4T/ddI containing regimens), ineffective (dual therapy) and second-line or salvage regimens.

By December 2005, 5,695 private patients received ARVs. Of those, 220 (4 percent) were under 15 years of age and 5,475 (96 percent) were 15 years or older. Of the adult patients, 4,868 (89 percent) received recommended regimens. A total of 376 patients (7 percent) received not-recommended, 179 (3 percent) ineffective treatment, and 52 (1 percent) second-line or salvage regimens. The number of patients receiving recommended treatment doubled in 2005. However, the number of not-recommended and ineffective treatments remained stable. Of the 845 (out of 5,475) adult patients in managed care programs, 95 percent received recommended, and none of the patients received ineffective treatment.

**Classification of ART Regimens dispensed by the Private Health Sector
Namibia, Dec 2003, Dec 2004 and Dec 2005**



In 2005, the private health sector accounted for more than 25 percent of the more than 21,000 patients on ART in Namibia and has considerable growth potential. To ensure universal high-quality care, ongoing training and clinical networking should be combined with managed care and mandatory accreditation.

Strategic Information

IMPACT/Namibia was instrumental in introducing the AIDS Impact Modeling (AIM) software package of the Futures Group in Namibia. AIM was used to project the demographic forecast used by the National Planning Commission for the development of the Second National Development Plan (NDP-2). In 2001, IMPACT/Namibia published the results of a consensus workshop of the demographic impact of HIV. This formed the scientific basis for the specific chapter on HIV/AIDS in NDP-2.

Sentinel surveillance surveys and routine HIV prevalence data

HIV sero-surveys have been conducted every two years in Namibia since 1992. Approximately 85 percent of all pregnant women attend ANC according to the MoHSS.

Results of the National Sentinel Surveillance among pregnant women in Namibia:

Sentinel site	1992	1994	1996	1998	2000	2002	2004	2006
Katima Mulilo	14%	25%	24%	29%	33%	43%	43%	39.4%
Oshakati	4%	14%	22%	34%	28%	30%	25%	27.1%
Grootfontein						30%	28%	19.3%
Onandjokwe		8%	17%	21%	23%	28%	22%	23.3%
Katutura, Windhoek	4%	7%	16%	23%	31%	27%	24%	21.1%
Oshikuku					21%	27%	27%	22.4%
Walvis Bay				29%	28%	25%	26%	22.1%
Tsumeb						25%	16%	17%
Otjiwarongo	2%	9%	n/a	16%	18%	25%	17%	18.7%
Outapi						23%	17%	21.1%
Rundu		7%	8%	14%	14%	22%	21%	20.1%
Nyangana		6%	5%	10%	16%	22%	15%	10.2%
Andara		2%	11%	16%	15%	21%	18%	22.2%
Engela		7%	18%	17%	23%	19%	18%	27.0%
Nankudu				13%	18%	16%	19%	13.9%
Keetmanshoop	3%	8%	n/a	7%	17%	16%	16%	18.5%
Swakopmund	35%	7%	17%	15%	22%	16%	28%	17.3%
Gobabis				9%	9%	13%	14%	7.9%
Mariental					10%	12%	11%	10.2%
Rehoboth					9%	10%	14%	13.9%
Opuwo	3%	1%	4%	6%	7%	9%	9%	7.9%
Central Hospital, Windhoek							10%	9.1%
Luderitz							22%	22.5%
Outjo - Korixas							12%	12.1%
Total	4.2%	8.4%	15.4%	17.4%	19.3%	22.0%	19.7%	19.9%

During the ANC visit, blood is routinely drawn from women and screened for anemia and syphilis. Every two years, during a given period, the blood samples are also screened anonymously and unlinked for HIV testing. In Namibia, sentinel sites were chosen based on regional coverage, geographic location (urban and rural), and the volume of ANC clients at each site. Inclusion criteria are pregnant women ages 15 to 49, current pregnancy, first-time visit, not referred from another ANC facility, and agree to routine blood drawing for syphilis screening.

IMPACT/Namibia assisted in the data analysis and preparation of the 2002 sero-survey report as well as in the preparation of the epidemiological report on HIV/AIDS and STD for 2001.

In 2004, the sero-survey showed a declining trend compared to the data from 2002; however, there has not been a further decrease in overall sero-prevalence according to the 2006 results released by the MoHSS¹⁶

IMPACT/Namibia also collected routine HIV prevalence data from PMTCT services at the five mission hospitals. In three of these hospitals (Rehoboth, Oshikuku, and Onandjokwe), coverage was above 90 percent with a large sample size. These data are therefore likely to be more reliable than the sero-surveys, which collect a smaller sample of women and therefore produce results with a large confidence interval. All PMTCT prevalence data are within the 95 percent confidence intervals of the sero-surveys of the respective years.

The overall HIV prevalence at the five IMPACT supported hospital sites fluctuates around the national weighted HIV prevalence of 20 percent.

HIV prevalence at PMTCT Sites supported by IMPACT/Namibia:

Site	Andara	Nyangana	Oshikuku	Rehoboth	Onandjokwe	Weighted Total
Sero-survey 2004	17.9%	14.9%	27.0%	14.3%	22.1%	20.5%
Sero-survey 2006	22.2%	10.2%	22.4%	13.9%	23.3%	20.8%
PMTCT 2004	15.9%	26.4%	20.3%	11.8%	24.6%	20.4%
PMTCT 2006	16.5%	15.0%	22.0%	8.3%	21.1%	19.5%

Establishment of a computerized system for patient management

People with HIV need integrated services from interdisciplinary teams of doctors, nurses, pharmacists, laboratory staff, (lay) counselors, and treatment supporters. For patient management, each staff member usually collects and documents specific information or instructions.

In a paper-based system, information from the same patient is often repeatedly collected by different staff members and information flow is difficult to control. Data analysis is time-consuming and is usually limited to compiled information collected through tally sheets. For effective management of HIV, it is important to collect a detailed history of the patient during the initial visit and keep track of the treatment regimens, the clinical and immunological response to treatment and occurrence of side effects and complications. During the many years of ART, important quantities of medical data are collected for each patient and managing medical files becomes increasingly challenging. A computer-based system, using a local area network has the potential to increase the efficiency of services, improve the access to relevant

¹⁶ MoHSS 2006 Sentinel Surveillance

information, streamline pharmaceutical management, and facilitate periodic reporting and generate summarized medical records. Moreover, it can generate computerized longitudinal patient records that can be used for cohort analysis to evaluate service outcome.

IMPACT/Namibia therefore searched for existing computer programs that could operate in a network in an integrated system and could handle a large quantity of data. In Windhoek, a private clinic was identified which worked with a South African company that developed software for managing primary healthcare clinics. This company was willing to make the software available in exchange for funding of the development costs of a specific module for managing patients with HIV. Data entered in this system could be exported in the electronic format of the data capturing system of the MoHSS (based on Epi-Info) developed during the same period, but did not have the potential to work within a local area network.

The system was used in two hospitals of Catholic Health Services and three private clinics for patient management and pharmacy management at the end of the project.

LESSONS LEARNED AND RECOMMENDATIONS

1. Work Simultaneously at the Systems, Community, Family, and Individual Levels

Measurable and concrete impact requires a multifaceted and holistic approach. A key element of this approach is to establish the necessary legal and policy framework within the government, and to avail their infrastructure (buildings, staff) to maximize service delivery, communication, and the coordination of care.

Work with government and traditional leaders. IMPACT/Namibia systematically built partnerships with the relevant authorities at government ministries. Government leaders need to understand and support a wide-ranging strategy involving HIV prevention and mitigation in the workplace and at family and individual levels. To encourage this understanding, HIV/AIDS programs should support government efforts to create a legislative environment that favors families and children in need. If a supportive environment is not in place, HIV programs must also support community organizations to become advocates for children and families, both for the development of relevant laws, policies, and guidelines, and for their enforcement once they are disseminated.

In Namibia, broad-based leadership support was essential in the promotion of VCT, treatment adherence, and the provision of care by volunteers at local levels, as well as in the expansion of educational opportunities and other benefits for OVC. Traditional leaders also played a key role, as IMPACT/Namibia learned when they reached out and secured the personal commitment of nearly all kings and chiefs in the country. Each of these traditional leaders held one or more educational forums that attracted thousands of community members for information, referral, and support on issues related to the prevention, care, and treatment of HIV/AIDS.

IMPACT's experiences in Namibia demonstrated that providing direct support to caregivers and households was best achieved through intermediary agencies that operated at the community level. It was important to choose partners that were able to get the funding and resources to where it is needed on the household level. The effectiveness of such agencies depended largely on the quality of national volunteering initiatives to assist directly at the community level. One lesson learned is that palliative care and OVC programs should explore ways of how volunteers can best be recruited, trained, supported and retained. Partner organizations found it challenging to recruit staff in certain skill areas, such as management and M&E; therefore, organizations must be continuously supported to develop their own capacities to be able to render more effective services to communities. There is also a need for continuous coordination and networking of service providers to share information and best practices.

Take a holistic approach: address root causes of vulnerability. Addressing HIV-related issues within the context of underlying root causes, as well as broader issues of human rights and poverty alleviation, is the approach endorsed through international agreement and national policies, such as the UN Convention on the Rights of the Child. The challenge is to convince donors to look beyond HIV-related issues and to provide funding for underlying causes.

Mitigating the spread of HIV requires attention to gender and educational issues, including but not limited to safer schools and other basic education interventions that reduce infections and

vulnerability of affected children. Community-based research by the Johns Hopkins University Health Communication Partnership¹⁷ demonstrated that community members felt that joblessness, poverty, domestic violence, and alcoholism were the major issues their community faced, thus relegating HIV to a secondary position.

FHI's implementing partners often pointed out that clients engage in risky sexual behavior because they need the money, or avoid ARVs because they don't have the proper nutrition on which the medication depends. For example, an FHI staff member recalls a visit to Nyangana, a poor village in the far northeast of Namibia that is served by CAA, where a woman living with HIV said, "I don't want to take the pills because they make me feel stronger, and then I feel hungrier and that hunger feels even worse (than I do now) because I don't have any food to eat." Partnership and linkages with organizations outside of the traditional health sector are critical, including those related to microfinance and vocational skills training.

Listen to the voice of the people who are affected. When addressing issues of HIV prevention and care, especially in combating stigma and discrimination and ensuring access to needed services, it is critical that programmers at all levels ensure the Greater Involvement of People Living with HIV/AIDS (the "GIPA" principle), and similarly, that they find meaningful ways to involve children and youth in the decisions that affect their lives. Involving those who are affected is an effective practice, because they understand their own needs the best and have a right to be consulted. Often times they will observe things others have overlooked or do not consider important. Planning cycles, implementation, and review should also include assessment and feedback sessions with the communities involved, to ensure their investment and long-term commitment.

2. Work with Faith-Based Organizations

IMPACT/Namibia's strong partnerships with FBOs were to the effective and low-cost scale-up of the project. Involve grassroots interventions that can mobilize communities and foster change among families and individuals was also essential to the project's success. Several lessons can be learned from this approach:

Build on existing infrastructures. Local churches and other FBOs can provide an active and engaged audience. They also have buildings that can be used for meetings and other support services, access to local resources and influential decision-makers, and various internal committee structures that can be mobilized to effectively bring services to the people who need them most. In addition, when existing leadership is properly trained and committed to HIV care and prevention, they can address stigma and positively influence large portions of the society on issues of health, interpersonal relations, education, and the care of OVC.

Respect church values. Donors must be flexible to adapt program strategies to fit church ideologies, and they must actively work to find other partners to fill service gaps. A good example of this is emphasis placed by FBOs on abstinence and being faithful, values that remain core components of HIV-prevention interventions and are readily understood and accepted by

¹⁷ Namibia HIV/AIDS Research: Baseline and mid-term results from the household surveys, network analyses, and community assessment findings 2005/2006. Johns Hopkins University Center for Communication Programmes, Health Communication Partnership, Windhoek, Namibia 2006.

their constituencies. Where FBOs are often reluctant to discuss contraceptive issues, donors must seek other partners to address this gap as part of the comprehensive prevention approach to behavior change in regards to HIV and reproductive health. It should be recognized that prayer has tremendous meaning and influence for many people, but it is never a substitute for needed medical care or other critical interventions.

Many church leaders and groups are reluctant to discuss sex or sexual health, particularly with youth. Programs should build in a strong component of sensitization and advocacy to these leaders to ensure their full cooperation and endorsement of project activities. Involving FBO leaders from project inception is paramount for future implementation. IMPACT/Namibia found that most leaders, once they are fully briefed and sensitized on the objectives of the project, do not object to its implementation. If they are fully informed, FBO leaders often become the driving force behind the project, encouraging others to participate. Failing to do so may result in unnecessary confusion and misinformation.

Begin at the grassroots level. Scaling up is more effective if it begins at the local level, rather than using a top-down approach. Working through FBO structures enables projects to reach the individual level through structures that are personal and respected. Messages that attempt to change behavior are most effectively spread by interpersonal communication and example. Most FBOs have groups, such as women's or choir groups, that provide ready audiences for awareness-raising, and are excellent resources for reaching the population on a personal basis. In addition, programming at the grassroots level will also ensure that interventions are culturally appropriate and tailored to local situations.

Provide ongoing capacity building. Despite the many advantages, most churches and FBOs have limited capacity in terms of management and advocacy skills, human resources, and donor experience. After the initial training, it is necessary to provide regular follow-up visits, mentoring, hands on training, refresher courses, and encouragement to avoid burn out and dropouts as well as to ensure quality provision of services. This includes capacity building not only in technical aspects of the intervention to be undertaken, but also in the programmatic and financial management of donor funds.

Maintaining motivation: supporting the work of volunteers. FBOs usually have a ready cadre of volunteers that can be mobilized and trained for community outreach, care, and support in the community. In addition, FBO volunteers—most of whom are rural women—are strongly motivated by the desire to help their neighbor, practice the principles of their faith, and learn new skills to help themselves and others. Incentives are important to them, but seemingly play a secondary role.

Most volunteers in Namibia are older women who are based in the rural areas, and are motivated by their religious beliefs, including charity and assistance to their neighbors. Most take care of sick relatives and/or OVC in their own homes in addition to the work they do in the community. For this group, incentives play a secondary role. They are happy to learn new skills, achieve recognition in the community, and help themselves and others. By contrast, younger and more

urban volunteers typically unemployed and rely on incentives to maintain their own involvement while caring for their own and their families' needs¹⁸.

IMPACT/Namibia worked closely with several implementing partners to find a reasonable and sustainable solution to these issues, which also avoids a legal complication. Examples of successful incentives for volunteers include: items of clothing that they use while performing their duties (T-shirts, transport allowance, home-based care bags, and umbrellas), food supplements during a drought, access to income-generating opportunities, celebratory events and awards, and small sums of money to share with their families, particularly around Christmas and Easter.

Organizations offer incentives of a different value than those used by IMPACT/Namibia, which proved to be a very sensitive and critical issue. It is important to agree upon national guidelines for incentives that both fosters the voluntary sector and provides acknowledgement and continued motivation for the volunteers who are providing an invaluable service.

3. Build Technical and Management Capacity

After 110 years of colonialism and apartheid that ended in 1990 with Namibia's independence, the challenges remain immense. Among the most intractable for the fight against HIV/AIDS is the lack of skilled Namibians to manage the responsibilities needed in both the public and private sectors. It is not only that specialty skills must be taught around prevention, treatment, and care, it is the lack of basic skills such as literacy, job-readiness, and experience. Even where individuals are eager to learn, often the particular discipline that is needed is not available in Namibia. Namibia does not have a medical or pharmacy school, and there is no institution of higher learning where the principles of project management can be learned.

Leadership training and capacity-building are core themes that must be applied continuously, using a variety of methods. Multiple workshops and longer-term courses, distance education, on-site mentoring, exchange-visits with follow-up, on-site supervision and consultation, and the development of specific curricula that are translated into local languages are all examples of such methods. The principles of ongoing training and support also apply to the involvement of volunteers who constitute the backbone of most community-based HIV work in Namibia, and whose indelible contribution is often overlooked. Technical, managerial, and other capacity should be strengthened to deal with the needs for scaling up and ensuring sustainability of a maturing HIV/AIDS program. Technical support for local implementing partners should not only come in the form of meetings, workshops, and written materials, but should also be provided in the field, tailored to each organization to refine interventions where necessary.

The impact and sustainability of local services can be enhanced by developing appropriate frameworks for implementing partners on minimum standards and quality assurance, such as the FHI focus on the development of a program planning and supervisory checklists for home-based care and for quality assurance around the care and support of orphans and vulnerable children.

¹⁸ Ministry of Health and Social Services, Namibia, "Report of an Assessment of Community-Based Volunteers and Community-Based Health Care Programmes, November 2006.

Take a long-term approach and work cooperatively. With short-term funding cycles and the need to show results, the complexity of issues being addressed can be easily overlooked. In particular, issues of prevention and care touch upon established cultural values, where great sensitivity is required. Even as we know that some of these customs have to change to bring down the rate of HIV infection and mitigate its impact, other traditions—especially those of family-based care and community support—are the very strength of African societies and must be nurtured and even further strengthened for the future. Multiple strategies are required to reinforce the messages. Similarly, institutional growth and the development of human-resources are time-consuming and expensive, and must involve a wide range of stakeholders for there to be a long-term impact.

IMPACT/Namibia recognized that linkages should be strengthened between partners and with key stakeholders at each level within the health, education, and social services sectors, other parts of government, and civil society. To that end, implementing partners met together regularly, shared materials, and joined together for training sessions, special activities, and planning purposes. FHI also conducted advocacy and information dissemination at the national, regional, and local level directly and through local implementation agencies.

4. Behavioral Formation Before Behavioral Change

Issues of prevention and care touch upon deep-seated habits and cultural values, where great sensitivity is required. Even as we acknowledge that traditional gender roles have to change to bring down the rate of HIV infection and mitigate its impact, other traditions, especially those of family-based care and community support, must be nurtured, as well as continuing to lead by example. During their early years, young people learn, explore, and make decisions that will affect the rest of their lives. If they do not receive information and services to make informed decisions, they are more likely to engage in unsafe behaviors that could have long-term adverse consequences—high rates of early pregnancy and sexually transmitted infections, drug addiction, in addition to low self-esteem and being prone to abuse.

Working with young people through peer-education, participatory drama, youth clubs, and school- or church-based programs meant that implementing partners were trying to *form* responsible behaviors from a very early age, so as not to have to *change* them later on, when it might be too late. Peer educators must be trained and carefully supervised, and because actions speak louder than words, they must be good role models for the youth. Behavioral formation must occur at a community level with the support of parents and guardians, involve experiential learning and be entertaining, and address issues of self-awareness, communication skills, self-esteem, decision-making, and problem-solving skills. Hence, with this group, the focus should be almost exclusively on abstinence and the delay of sexual debut. For older children (e.g., 15 years and older) and for adults, these lessons may be reinforced, but additional emphasis is placed on being faithful and on the use of condoms, especially for those who are sexually active.

Clarity, consistency of message, and cultural sensitivity are also important, as demonstrated by IMPACT/Namibia's development of reproductive health flipcharts and manuals for peer educators.

5. Provide Comprehensive Integrated One-Stop Prevention, Care, and Treatment Services

By providing integrated, quality and local services, the five faith-based hospitals were able to attract and provide services for many clients as a one-stop-shop. However, these clients form only a small proportion of people in need of services. Thus, Namibia's main challenge for PMTCT and ART is making these expanded services more accessible to people in rural areas by rolling out PMTCT and routine follow-up of HAART services and distribution of ARVs at the district health centers and clinics. This will facilitate access to treatment and also reduce overcrowding at district and referral hospitals.

The strength of the integrated programs at the mission hospitals and many other health facilities in Namibia lies in their close collaboration with community-based organizations such as CAA, ELCIN AIDS Action, ELCAP, the American Red Cross, and many others. As these organizations expand their services, health facilities should assist them in providing treatment, support, and TB and palliative care. IMPACT/Namibia recognized that linkages should be strengthened between partners and with key stakeholders at each level within the health, education and social services sectors, other parts of government, and civil society. One organization alone cannot provide all aspects of comprehensive prevention, care, and treatment, thus, this collegial partnership is essential to avoid duplication, identify and fill gaps, and ensure that each organization is working to implement the best quality interventions according to their comparative advantage.

HIGHLIGHTS OF IMPLEMENTING PARTNER ACTIVITIES

Implementing Partner Matrix for IMPACT/Namibia

Name	Organizational Type	Geographic Region	Target Population	Budget	Intervention	Project Dates
AIDS Care Trust (ACT)	NGO	Khomas	Labor force	\$200,494	Peer education, BCC	April 1, 2001, to April 30, 2005
Apostolic Faith Mission (AFM)	FBO	Otjozondjupa	OVC, PLHA, community	\$29,980	PSS, AB Community HBC	April 1, 2001, to June 30, 2006
Catholic AIDS Action (CAA)	FBO	National	OVC, PLHA Youth	\$2,150,731	PSS, BCC, prevention, Community outreach, HBC	April 1, 2001, to June 30, 2006 August 15, 2003, to June 30, 2006 February 1, 2004, to June 30, 2006
Church Alliance for Orphans (CAFO)	FBO	National	OVC	\$220,216	OVC	October 1, 2004, to June 30, 2006
Catholic Health Services (CHS)	FBO	Hardap, Omusati and Kavango	Pregnant women, PLHA	\$4,432,704	PMTCT, ARV, VCT	August 15, 2003, to May 31, 2006
Chamber of Mines (COM)	Private Sector	Khomas, Erongo, Oshikoto, Otjozondjupa Karas	Labor force	\$124,714	Peer education, BCC	March 15, 2001, to June 30, 2006
Clinicians Society	Private Sector	National	Clinicians	\$24,589	Clinical Training	April 1, 2004, to June 30 2006
Evangelical Lutheran Church in the Republic of Namibia AIDS Program (ELCAP)	FBO	Hardap, Karas, Erongo, Otjozondjupa, Khomas	General Population, PLHA, OVC	\$594,302	Community Outreach, VCT. HBC OVC	October 1, 2003, to June 30 2006
Evangelical Lutheran Church in Namibia (ELCIN AIDS Action)	FBO	Omusati, Oshikoto, Oshana, Otjozondjupa	General Population, PLHA, OVC	\$589,947	Community Outreach, HBC OVC	February 1, 2004, to June 30, 2006
Legal Assistance Centre (LAC), AIDS Law Unit	NGO	National	PLWA, labor force, OVC,	\$401,345	Advocacy, policy, stigma reduction	April 1, 2001, – June 30, 2006

			policy makers			
LifeLine/ChildLine	NGO	National	Youth, Community counselors, PLHA	\$1,251,362	Prevention, drama, radio Training and counseling	February 1, 2003, to June 30, 2006 September 1, 2003, to June 30, 2006
Lutheran Medical Services (LMS)	FBO	Oshikoto	Pregnant Women	\$998,208	PMTCT, ARV, VCT	October 1, 2003, to June 30, 2006
Ministry of Education, HIV Unit (HAMU)	Government	National	Youth	\$49,928	Capacity building, M&E database	March 1, 2004, to June 2005
Ministry of Gender Equality and Child Welfare (MGECW)	Government	National	OVC	\$317,630	Technical Advisor, policy, training	April 1, 2001, to September 30, 2007
Ministry of Health and Social Services (MoHSS)	Government	National	General	\$136,441	Technical Advisor, M&E, assessments, guidelines	April 1, 2001, to June 30, 2006
Namibian Association of Local Authorities (NALAO)	Parastatal	National	Municipal Staff	\$33,202	Development of Strategic Plans	October 1, 2001, to September 2003
Ombetja Yehinga Organization (OYO)	NGO	Kunene, Erongo and Khomas	Youth	\$124,193	BCC, prevention	March 15, 2001, to December 30, 2004
Rhenish Church	FBO	Hardap	OVC	\$23,929	PSS, education	April 1, 2005, to June 30, 2006
Philippi Trust Namibia	FBO	Hardap, Oshana, Khomas, Omaheke	OVC	\$301,213	PSS, Experiential learning camps, kids clubs	September 1, 2002, to June 20, 2006
Sam Nujoma Multi- Purpose Center (SN MPC)	NGO	Oshana	Youth, OVC, Community	\$57,327	BCC, VCT, workplace/ community/school programs	April 1, 2003, to June 30, 2006
<i>The Namibian YouthPaper</i>	Private Sector	National	Youth	\$72,642	BCC	March 15, 2001, to December 30, 2004
TKMOAMS	NGO	Omusati, Oshikoto, Oshana, Otjozondjupa	OVC, PLWA	\$82,253	HBC, PSS	October 1, 2004, to June 30, 2006
Walvis Bay Multi- Purpose Center (WB MPC)	NGO	Erongo	Youth, Community, labor force	\$585,497	BCC, VCT, workplace/ community/school programs	May 1, 2001, June 30, 2006

DAPP-Hope Humana	NGO	Omusati	Youth	\$25,092	Bridge funds for GF	November 1, 2003, to June 30, 2004
Diamond Health Services	Private Sector	National		\$84,404	Development computerized system for patient management	June 1, 2004, to March 31, 2006
Namibia Resource Consultant	Private Sector	National		\$38,382	Development of GF proposal Round 2 Namibia	September 1, 2002, to February 28, 2003
SIAPAC	Private Sector	Erongo, Khomas, Oshana	Local authorities	\$134,674	Assessment of Economic impact of HIV on municipalities	July 1, 2001, to August 31, 2003
Rapid Response Funds	Various NGO's	National	OVC, PLWA, general population	\$25,049 \$45,401	HIV prevention, support to OVC	November 1, 2001, – September 30, 2003

Subproject Highlights

Implementing Agency:	AIDS Care Trust (ACT)
Geographic focus:	Khomas region, some regional outreach
Target population:	Workforce
Length of support:	April 1, 2001, to April 30, 2005
Level of support:	\$200,494

Organization Profile

AIDS Care Trust (ACT) of Namibia was constituted as a Trust in 1992 and began activities in June 1993, having as its primary objective the provision of comprehensive care and support services for people living with HIV/AIDS. In 1999, to respond to a growing demand, ACT expanded its activities to include workplace programs. The organization strives to combat the HIV/AIDS epidemic in and around the Windhoek area through an innovative combination of HBC services, pre- and post-test counseling and the provision of information, education, and communication in the workplace.

Background

In 2001, as ACT was expanding its workplace activities, IMPACT/Namibia provided the organization with financial and technical resources to develop a workplace prevention module to be used by ACT (and other organizations) to sensitize management, unions, and employees in targeted work sites, emphasizing the cost to business, the community and the individual of the effects of HIV/AIDS, and the benefits of an integrated prevention program.

Accomplishments

ACT staff was instrumental in developing and field-testing the Peer Educator Toolkit described in other parts of this publication. The development of the PE Toolkit took place over a two-year period, involved four other IMPACT-funded organizations (Chamber of Mines, Walvis Bay, and Ongwediva MPCs, as well as the Legal Assistance Centre) through a series of workshops, field tests, and revisions to finalize the toolkit. During the training of trainers, focus was placed on management commitment for program inputs such as employee release, space, and equipment. In addition, the workplace program was based on “a fee for services” module, whereby the private sector was required to contribute to training costs and periodic supervisory visits. Over time, ACT developed and applied a strategic approach to workplace education. This involved presentations to managers, cooperation with experts in the field of policy formulation, training of peer educators, supervision of sessions, and counseling provided by ACT staff trained in home-based care. ACT worked closely with other Namibian service providers such as the AIDS Law Unit of the Legal Assistance Centre and the Social Marketing Association (condoms). Referral systems ensured that gaps could be filled where ACT had no expertise. During the four-year period of support, ACT trained 359 peer educators in 22 workplaces, reaching, on average, 6,000 workers with prevention and care messages each year. The ACT workplace program is presently funded through the Global Fund.

<p>Implementing Agency: Geographic focus:</p> <p>Target population: Length of support: Level of support:</p>	<p>Apostolic Faith Mission Church (AFM) Otjozondjupa (with some outreach to villages in Oshana, Ohangwena and Oshikoto) OVC, PLHA, community April 1, 2005, to June 30, 2006 \$29,980</p>
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Organization Profile

The Apostolic Faith Mission (AFM) church is the oldest and largest Pentecostal church denomination in Namibia, with 110 congregations around the country. AFM AIDS Action (AFMAA), funded in April 2005 under PEPFAR, has proven itself as one of Namibia’s newest and effective providers of HBC. Relying on a dedicated team of volunteers, AFMAA serves the population at large. Its volunteer base is mobile and responsive: visiting homes and hospitals to provide needed care.

Background

AFMAA uses a holistic approach that is based on training received from CAA, ELCIN AIDS ACTION, and CAFO. AFMAA offers prevention awareness programs, HBC, counseling and referrals, and OVC support. Local funding leveraged by AFMAA supports a large feeding program in Grootfontein’s informal settlement that focuses on OVC.

Accomplishments

Support and technical assistance received from IMPACT/Namibia enabled AFM to provide training, support, and quality-assurance supervision to all volunteers who, in turn, provide home based care, counseling, referral and advocacy, and support to PLHA and their family members



Photo courtesy of Dr. Lucy Steinitz, Family Health

within their respective town or village, or on a house-to-house basis. Volunteers register orphans and vulnerable children in accordance with the MGECW, refer them for services to which they are entitled (e.g., an exception in the payment of school development funds for OVC attending primary school, waiving the co-pay for medical treatment, etc), and provide emotional support, planning, and direct care for (and with) OVC living in the community.

The “Hearts, Hands, and Voices” soup kitchen serves more than 500 children weekly. Although AFMAA is concentrated in the north-central area of the country around Grootfontein, it also reaches nine different communities in three regions, working under difficult

conditions, without a vehicle. Most of its training sessions take place in a tented church, in all kinds of weather. They sing, pray, and learn together. Working closely with government officials, it provides information, referrals, hands-on care, and follow-up.

Speaking about a volunteer, the AFM coordinator said: “She comes into the office every Tuesday and Saturday before she visits clients. If there is a specialized service that she cannot provide, for example, some detailed counseling on ARVs, then she asks for a specialist to come out. She is also a great encouragement to the other volunteers at the church. Noticing when a volunteer misses a week she goes and supports them, trying to encourage them to continue with their work.” In the 15-month period, AFM reached more than 11,000 people with their abstinence and faithfulness messages, served close to 2,000 OVC through a soup kitchen, and provided PSS to 75 OVC through kids clubs. AFM has 100 active volunteers who care for more than 700 PLWA.

Implementing Agency:	AIDS Law Unit
Geographic focus:	National, all 13 regions of Namibia
Target population:	Work force, OVC, PLWA, community
Length of support:	April 1, 2001, to June 30, 2006
Level of support:	\$401,345

Organization Profile

The **AIDS Law Unit (ALU)** is a project of the Legal Assistance Centre, a nonprofit public interest law center established in 1988. ALU began in 1989, based at the office of the Legal Assistance Centre in Windhoek. The goal of the ALU is to facilitate the establishment of a legal and social environment that encourages openness about HIV infection in which people with HIV/AIDS receive fair and equitable treatment from society. The ALU addresses issues of HIV discrimination and provides an avenue for remedies for PLHA who have been discriminated against on the basis of their HIV status.

Background

The AIDS Law Unit of the Legal Assistance Centre focused on the prevention and mitigation of HIV/AIDS in the workplace by addressing discrimination and promoting a human-rights-based approach to HIV/AIDS through the establishment of a legal and social environment. The ALU program complemented other FHI partner programs through training, legal support, and the formulation of appropriate policies in the workplace within government and in civil society.

Accomplishments

With support from IMPACT/Namibia, 43 HIV/AIDS policies for the workplace were developed for implementation. These policies ensured access by PLHA to employment and corresponding benefits, and protects those already employed against stigma and discrimination. Every year, the ALU conducted legal and human-rights education and training related to HIV/AIDS for key stakeholders (governmental and nongovernmental) in all 13 regions of Namibia. In support of these trainings, they developed a training manual on HIV and the law for community paralegals, illustrated pamphlets and booklets on HIV/AIDS in the workplace, insurance and social benefits, how to write a will, rights of widows and OVC. Specifically to support workplace activities, the ALU printed and distributed 5,000 copies of *HIV/AIDS in the Workplace*, a pocket-size booklet summarizing basic facts about HIV/AIDS, rights of HIV-positive workers, recourse, and benefits. The booklet was translated in Afrikaans and Oshindonga.

A treatment literacy campaign was initiated by the ALU that sought to raise awareness and understanding about HIV/AIDS treatment as a human right. This took the form of the production and distribution of T-shirts, posters, and booklets on access to treatment as well as the production of a series of radio programs about access to treatment broadcast on the community, local, and national NBC radio. The ALU also chairs the Treatment Action Forum (TAF) to raise awareness, understanding, and advocacy about HIV/AIDS treatment as a human right. The ALU worked with the Government of Namibia in the development of the National OVC and Education policies, as well as the National HIV/AIDS Policy for Namibia. In addition, with IMPACT funding they provided training to stakeholders in all 13 regions on the implementation of the National OVC Policy.

Implementing Agency:	Catholic AIDS Action (CAA)
Geographic focus:	National
Target population:	Youth, OVC, PLWA, community members
Length of support:	April 2001, to June 2006
Level of support:	\$2,150,731

Organization Profile

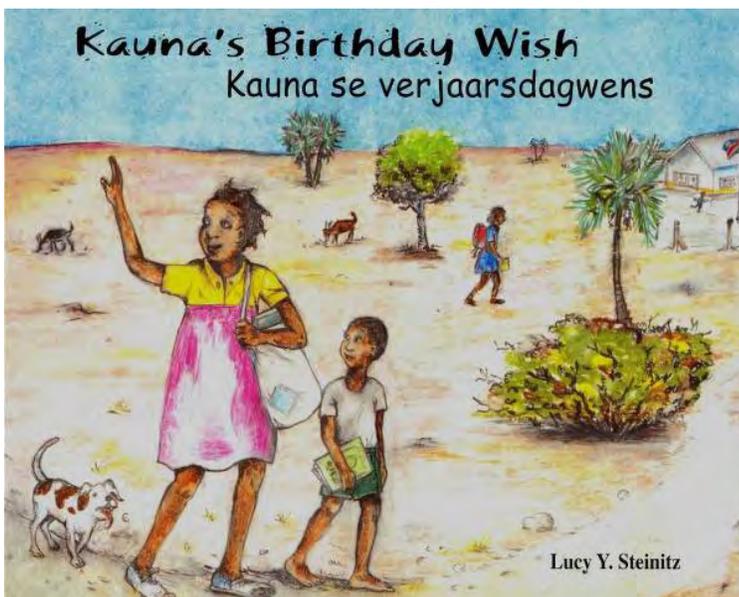
Catholic AIDS Action (CAA) was founded by the Namibian Catholic Bishops Conference in 1998. CAA’s motto is “the courage to fight and strength to care.” While CAA approaches both prevention and care activities within a Christian context, it serves all the people of Namibia regardless of religious affiliation. CAA was the first faith-based organization FHI worked with to increase access to education opportunities for OVC and to improve the capacity of their community-based volunteers to provide psychosocial support to the orphans in their community.

Background

From very humble beginnings with just two volunteers and permission by the Namibian Catholic Bishops’ Conference to “go out and organize,” CAA grew to become the largest NGO working in HIV/AIDS in Namibia. The organization builds on its network of 91 parishes, more than 300 outstations (small Christian communities), 16 Roman Catholic hospitals and healthcare institutions, and 31 affiliated schools and hostels, as well as its partnerships with other churches and faith-based organizations, NGOs, the business sector, and government ministries, including the MoHSS and MGECW. At the core of CAA is its more than 1,500 active volunteers located in 118 church-based groups around the country. CAA offers training at the national and local level on HIV prevention, HBC, counseling, and psychosocial support of OVC, funded through IMPACT/Namibia. It has also spawned many local soup kitchens, after-school programs, and weekend or holiday camps, often in conjunction with other USAID partner organizations.

Accomplishments

CAA’s Schooled for Success project sought to increase access to education opportunities for



OVC. During the six years of IMPACT support, CAA provided close to 25,000 OVC with educational and psychosocial support. CAA advocated for the elimination of school fees and by providing school uniforms and related supplies ensured OVC could attend school. When this IMPACT – supported program started in 2001, with just 100 children, many of the orphans that the volunteers visited were not attending school, or were being stigmatized within the classroom for not wearing a uniform and not having the requisite school supplies. Every child can now attend school, and personnel are being sensitized to avoid

any kind of stigmatization. In support of this process, CAA published a children's book as part of its advocacy for 100 percent school enrollment. CAA, with support from IMPACT/Namibia, wrote and launched a children's book "Kauna's Birthday Wish" in three languages, English, Afrikaans and Oshindonga. "Kauna's Birthday Wish" is a children's book that offers hope to thousands of OVC by providing information on how to receive a free primary education, which is guaranteed under the Namibian Constitution.

The Ministry of Basic Education, Sport, and Culture formally launched the book, and two copies were distributed to each primary school in the country. Kauna's Birthday Wish was widely reviewed on TV, national radio, and the print media in Namibia. It is also available at after-school centers, OVC programs, and in bookstores.

With financial support from the Namibian Teachers Union (NANTU), the Canadian Teachers Federation, and Sister Silke from St. Mary's Hospital in Mariannhill, South Africa, CAA wrote "Building Resiliency among Children Affected by HIV/AIDS." The manual was translated into five other languages and IMPACT/Namibia financed the translation of the Afrikaans and Oshindonga versions. This manual reinforced and supplemented the various training programs on OVC in Namibia. CAA volunteers used the manual in more than 7,000 visits to affected households, and CAFO and other organizations ensured that each of their trained caregivers received their personal copy upon graduation.

The CAA Youth Education and Prevention (YEP) program focused on HIV prevention, and included information, activities, and discussion of abstinence, delay of sexual debut, mutual faithfulness, and partner reduction. The YEP program played an important role with young people by improving their communication and relationship skills. CAA incorporated the broader, critical issues related to HIV transmission into awareness, education, and prevention curricula. This new emphasis included not only the basic information regarding the transmission of the virus, but increasingly, peer discussion and interaction about issues of human sexuality, development, gender, HIV infection, substance abuse, and communication that influence both individual and community norms related to sexual behavior decision-making. Under IMPACT funding, 477 peer educators were trained and 13,993 youth participated in the YEP program.

CAA's HBC program was the first of its kind in Namibia and continues to serve as a model to all other HBC services in the country. Its early experience in grassroots, community-based care, support, and prevention-education positioned it very well to scale-up services in home-based and community care. Staff works with local church and community groups to recruit and train volunteers to provide home-based care, counseling, referral, advocacy and treatment-support on a household-by-household basis. On average, CAA volunteers provided care to 6,000 PLWAs each year of program. CAA was instrumental in the standardization of training across Namibian FBOs providing HBC support. In the final year of the program, with support from IMPACT/Namibia and the Global Fund, CAA developed "Standards for Home-based Care" and "Medical supplies in CAA's HBC Care Kit," two seven-page pictorial checklists to be used during home visit to ensure quality-assurance standards for HBC in Namibia are met. Both booklets were translated and printed into six languages and distributed to all IMPACT-supported organizations working in home-based care.

Implementing Agency:	Catholic Health Services (CHS)
Geographic focus:	Hardap, Omusati, Kavango
Target population:	Pregnant women, PLWA, community members
Length of support:	August 15, 2003 to May 31, 2006
Level of support:	\$4,432,704

Organization Profile

Catholic Health Services (CHS) has operated as a non-profit organization since October 2001, when it took over the management of the health facilities of the Catholic Dioceses in Namibia. CHS manages 16 health facilities throughout Namibia, including four district hospitals, five health centers, and seven clinics. A board of directors governs CHS. The Archbishop of Windhoek is the chairperson, the director of PHC and nursing services of MoHSS is a board member and liaison to the government. The government subsidizes CHS for running costs, capital investment, staffing, and medical/hospital supplies. There is a strong link to Catholic AIDS Action for outreach, care, and support programs.

Background

The experience of IMPACT/Namibia in building capacity of faith- and community-based organizations in collaboration with the MoHSS for OVC programs during 2001 and 2003 showed the potential of the churches and FBOs to mobilize communities to respond to HIV/AIDS. IMPACT/Namibia and USAID recognized the need for comprehensive services for prevention, care, and treatment of HIV/AIDS. Consultative meetings were held with CHS and the Lutheran Hospital in Onandjokwe (LMS), as well as a facility survey and staff interviews conducted by FHI staff at the five hospitals. The results led to the integrated “one-stop service” strategy for PMTCT, CT, and ART services. These “one-stop” centers would work in both directions: patients are referred from other services (ANC, TB, hospital wards, OPDs, peripheral



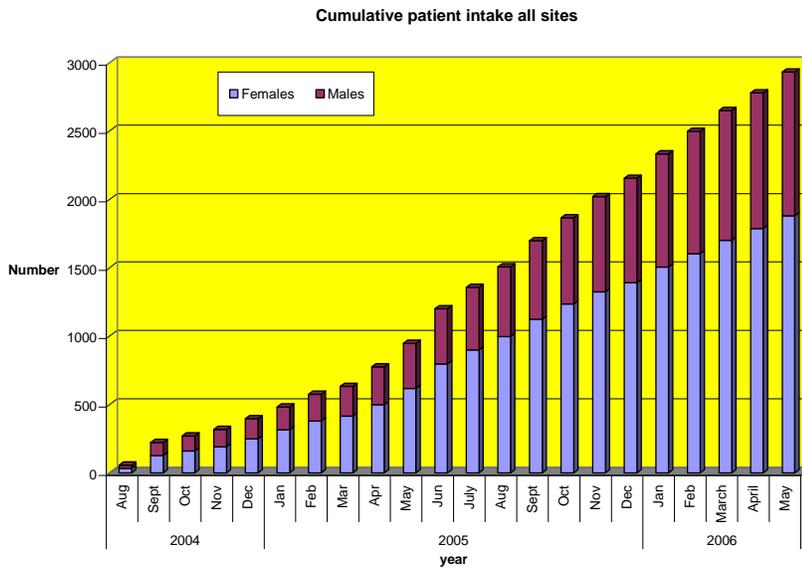
health centres, and HBC) and, patients are referred out for specific support or routine care to peripheral health centres, clinics, or HBC organizations. Through intensive capacity building in PMTCT, CT, ART and HIV management, in concert with ongoing community outreach and demand creation, the integrated services ensure efficient diagnosis and care for patients with HIV and increase access, availability, and uptake of quality treatment and care services.

Dr. Awa, CHS, Mr. Newton, USAID and Ms. E. Onjoro, OGAC at opening of the Oshikuku integrated center

Accomplishments

PEPFAR provided significant resources to IMPACT to upgrade CHS infrastructure, including construction and remodeling at existing health facilities, as well as computerized systems, vehicles for mobilization and follow-up of patients, and training of staff. By November 2004, all four hospitals had been upgraded and were providing expanded access to VCT, PMTCT, and ART services to the 200,000 people living in their respective catchment areas in northern rural parts of Namibia, as well as the Hardap region in the South.

ART cumulative patient intake from four CHS sites.



The above graph illustrates the tremendous efforts undertaken in ensuring PLWA are increasingly offered HAART free of charge at all four sites. The age distribution reveals that children account for only 15 percent of our total patient intake. Close to 3,000 PLWA were enrolled in ART, and the overall retention rate was close to 85 percent with the drop-out mainly related to case fatality (8 percent), transferred out (4 percent) and defaulter rate (3 percent). By the end of the IMPACT-funded period, more than 18,000 people had been tested and counseled at CHS, including more than 6,500 ANC women who were offered PMTCT services.

Implementing Agency:	Church Alliance for Orphans (CAFO)
Geographic focus:	National, but with a focus on the south-east
Target population:	OVC
Length of support:	October 2004 to June 2006
Level of support:	\$220,216

Organization Profile

Church Alliance for Orphans (CAFO) was founded in 2003 as an independent NGO, governed by a Board of Trustees, with a close affiliation to the Council of Churches in Namibia (CCN). CAFO is truly ecumenical, with its Board members representing the Lutheran and Catholic Churches in Namibia, the Apostolic Faith Mission, the African Methodist Episcopal Church, the Bahai community, and the Jewish faith.

Background

The members of CAFO operate through 62 ecumenical committees in towns or villages spread over all the 13 regions in Namibia. With the motto that “all children should be given the opportunity to fulfill their God-given potential,” CAFO’s goal is for every congregation and every local faith-based group in Namibia to have at least one program to help OVC.

Accomplishments

IMPACT/Namibia built the capacity of CAFO staff and volunteers to assist grassroots communities to implement locally inspired activities that offer supplemental material support and emotional support to OVC in the community. CAFO mobilized, intensified, and strengthened the response of local congregations irrespective of denomination, through the implementation of community-based programs to help OVC to grow up in a safer environment. CAFO supported 8,095 OVC through its 341 trained volunteers in 62 communities.



Gobabis Light for Children Group with Gary Newton, USAID.
Photo courtesy Lucy Steinitz

CAFO provides psychosocial and other care and support training, equips OVC and their caregivers with skills to enable them to start income generation projects.

Through Journey of Life mobilization workshops, CAFO aims for local communities to come up with their own assessment of local needs and resources, and thus, take as much local responsibility as possible for the care and support of OVC.

With technical assistance from IMPACT/Namibia, CAFO developed and was awarded a five-year US\$1 million grant under the PEPFAR New Partners’ Initiative. The CAFO director was invited to the White House to personally receive the award on World AIDS Day 2006.

Implementing Agency:	Chamber of Mines (CoM)
Geographic focus:	Coastal and Mining areas of Namibia
Target population:	Workers, their families and community
Length of support:	March 15, 2001, to June 30, 2006
Level of support:	\$124,714

Organization Profile

The **Chamber of Mines (CoM)** of Namibia represents the interests of all the major mining and exploration companies active in Namibia. With 60 members from an industry that makes up one-tenth of Namibia's Gross Domestic Product and half of its merchandise exports, the CoM brings together a wide variety of companies from the most important sector of the Namibian economy.

Background

Namibia has developed a comprehensive policy and legislative framework to address discrimination on the basis of HIV/AIDS in the workplace as outlined in the National Code on HIV/AIDS and Employment. The mining industry in Namibia has been in the forefront of implementing HIV workplace interventions. The Occupational Health Education and Awareness Program (OHEAP) originated at Namdeb (DeBeers) to deal proactively with the HIV/AIDS pandemic. In 1996, the Chamber of Mines of Namibia adopted the program to expand it among its members. In 2001, IMPACT was requested to provide technical assistance to assist the CoM in its expanding workplace program. In addition to IMPACT's support, core funding is provided by the Okorusu Fluorspar mine (Namibia), while the CoM provides office space and administrative support to the program.

Accomplishments

In 2001, IMPACT/Namibia provided support for the CoM workplace program, to build the capacity of its OHEAP team to improve the quality of its peer-education training program, to improve the monitoring of workplace programs, and to develop in concert with other local partners a workplace-specific training module to empower employees to assume responsibility for their health. The latter resulted in a workplace toolkit consisting of a training manual, flipcharts, brochures, and a peer educator guide in three languages. Over the six years of support, the program trained more than 1,200 peer educators, distributed more than 100,000 condoms, and reached close to 50,000 workers, their families, and community members through the 20 participating workplaces. The CoM worked with the ALU to develop workplace policies as well as to conduct training on legal issues, workers benefits, and rights of HIV-infected workers and their families. Over the years, several mines and affiliated businesses have taken ownership and integrated HIV/AIDS into their occupational health and safety programs, as well as providing support for ART and PMTCT. By June 2006, 13 out of the 15 active companies were providing ARVs under the company's medical aid schemes. As part of its annual general meeting, the CoM honors selected peer educators and provides a monetary prize for the top three peer educators. Individual companies also reward their peer educators by providing incentives (track suits, T-shirts, or monetary vouchers).

Implementing Agency:	Evangelical Lutheran Church AIDS Programme (ELCAP)
Geographic focus:	Khomas, Hardap, Karas, Otjozondjupa, Erongo, Omaheke, Oshikoto and Kunene
Target population:	PLWAs, OVC, affected families and communities, church and community volunteers
Length of support:	February 1, 2004, to June 2006
Level of support:	\$594,302

Organization Profile

In response to the increasing HIV epidemic in Namibia, the **Evangelical Lutheran Church AIDS Programme (ELCAP)** was established by a resolution of the Evangelical Lutheran Church of the Republic of Namibia (ELCRN) Synod in 1999. ELCRN determined that a comprehensive approach to HIV/AIDS should focus on caring for PLWA, orphans, and families affected by HIV/AIDS, as well as prevention through education and outreach to all congregations and networking with existing organizations.

Background

With its national office in Rehoboth, ELCAP maintains four regional offices—in Mariental, Windhoek, Otjiwarongo, and Karibib. Similar to ELCIN and CAA, ELCAP mobilizes local parish leaders to provide HBC and orphan support in 8 of the 13 political regions of Namibia.

IMPACT/Namibia supported ELCAP to upgrade its regional offices and renovate two church-provided buildings to serve as VCT centers in Rehoboth and Mariental. The VCT program was jointly supported by IMPACT and the Social Marketing Association, which implemented the New Start VCT Centers with PEPFAR funding in Namibia.

Accomplishments

With IMPACT support, ELCAP worked according to its five ELCRN circuits that span across eight regions to provide palliative care, support, and counseling through congregational volunteers, pastors, and other religious leaders. Community outreach activities focused on prevention strategies for youth, educational, and psychosocial support for OVC as well as the promotion of VCT, PMTCT, and HIV treatment. Capacity at congregational level was conducted through training in the Journey of Life (to build community-support for OVC) and Called to Care (helping congregations to do AIDS work), with follow-up coaching, supervision, and support by regional staff. IMPACT supported ELCAP to adapt and finalize its training curricula. Training of ELCAP staff was conducted in concert with CAA and Philippi Namibia, as well as IMPACT staff. Ten ELCAP TOTs trained 900 church volunteers in care and support. These volunteers worked through congregational AIDS committees to provide care and support to OVC and PLHA. ELCAP also trained community leaders in OVC rights, psychosocial support, and to advocate for full school participation by OVC by supporting waivers for school fees. With additional support from other donors, ELCAP also implemented training with youth in school hostels that fall under church auspices. ELCAP has more than 600 active volunteers serving more than 1,100 PLHA and more than 2,500 OVC.

Implementing Agency:	Evangelical Lutheran Church in Namibia (ELCIN)
Geographic focus:	Omusati, Ohangwena, Oshana, Oshikoto
Target population:	PLWA, OVC, community/church members
Length of support:	February 1, 2004, to June 30, 2006
Level of support:	\$589,947

Organization Profile

The **Evangelical Lutheran Church in Namibia (ELCIN)**, Namibia’s largest church-denomination, operates predominately in the northern and central regions of the country, with more than 600,000 members. It is rooted in the history of the Finnish Evangelical Lutheran Mission’s work in Namibia and retains strong ties with traditional leaders. In September 2000, the leadership of ELCIN wrote a position paper on HIV/AIDS to all its parishes, called “The Voice of ELCIN on AIDS” and now forms part of ELCIN’s strategy to combat the disease. In December 2000, ELCIN launched the ELCIN AIDS Action Plan as the HIV/AIDS program within the framework of both government policy and church teachings on prevention and care.

Background

With a core team of 15 staff members, ELCIN AIDS Action worked through its 124 parishes established prayer groups, parish AIDS committees, and HBC committees at all levels of the church structure. ELCIN also networked with other churches, the MoHSS health infrastructure, as well as key stakeholders within communities, such as religious and traditional leaders. ELCIN integrated HIV/AIDS awareness, training, prevention, and counseling activities into all programs of ELCIN church institutions, including its youth, students, men’s and women’s organizations, schools, and hospitals. The FHI YouthNet program supported the youth prevention component, while IMPACT funded ELCIN’s care and support program.

Accomplishments

Support from IMPACT/Namibia in early 2004 helped build the capacity of the ELCIN national and regional offices’ staff to train volunteers in community outreach to improve access to VCT, PMTCT, ART, HBC, advocacy, support and community. The ELCIN church worked closely with the traditional leadership to bring the messages to the people. In July 2004, King Taapopi, the traditional leader of the Uukwaluudhi Constituency in Northwest Namibia, became the first traditional leader to speak out publicly about HIV/AIDS. With the support from IMPACT/Namibia, the King joined ELCIN and other partners to hold a full-day educational conference on HIV/AIDS at the royal headquarters in Tsandi.



The King and USAID Mission Director, Gary Newton

King Taapopi spoke to more than 500 of his rural constituents to provide them with knowledge about the disease, and to warn them against the contributing factors of alcohol abuse, family violence and stigmatization. *“We have to fight (alcohol) tooth and nail as it is the main contributor to HIV and AIDS. If someone has a glass too many, then he or she starts to act irresponsibly. Alcohol also causes people to be violent and commit crimes of rape. You will find very young children being raped by men old enough to be their great grandfathers...I therefore appeal to all churches to fight this disease with prayers... and to all people, especially the young, to take care of each other and help each other avoid infection.”*

Following on the successful collaboration with the Uukwaluudhi Traditional Authority, ELCIN AIDS Action reached out to traditional leaders and jointly conducted ten additional education conferences with traditional leaders across northern Namibia, reaching more than 30,000 people.

ELCIN AIDS Action established 70 parish-based HBC groups. More than 600 active volunteers provide care for an average of more than 6,500 clients, which demonstrates the significant amount of care as well as the need for care that is present in Namibian communities. In addition to training parish- and community-based volunteers, ELCIN AIDS Action partnered with CAA and the AFM church to conduct Namibia’s first interagency Oshiwambo-language TOT for HBC and counseling and graduated 23 trainers from the three organizations. ELCIN registered 37,000 OVC with forms provided by the Ministry of Gender Equality and Child Welfare, and trained OVC coordinators for advocacy, referral, and emergency support in each of their parishes.

Implementing Agency:	HIV Clinicians Society
Geographic focus:	National
Target population:	Medical Professionals, mainly physicians
Length of support:	April 1, 2003, to June 30, 2006
Level of support:	US\$24,589

Organization Profile

The Namibian Branch of the Southern African **HIV Clinicians Society** was established in April 2003 with active support from IMPACT/Namibia. The Society supports a high standard and quality clinical care for people with HIV and AIDS. The Namibian HIV Clinicians society evolved from a branch of the Southern African Society to become a local, independent organization, while maintaining its regional links.

Background

Namibia has a very active private health sector, including private hospitals, doctors, nurses, pharmacists, and social workers. Large and medium-sized companies and the public sector provide access to health insurance for employees. Therefore a significant number of Namibians are covered under health insurance plans and use the private sector for health care. With support from IMPACT, the Society will be strengthened to provide adequate treatment according to national guidelines by providing training and networking among the service providers. By June 2006, the private sector was providing ART services to close to 25 percent (>5,000) of all patients on ART in Namibia. A review of treatment records by an FHI staff member in 2005 revealed that 85 percent of the patients in the private sector were treated according to the national guidelines, a 50 percent increase in correct treatment compared with 2004.

Accomplishments

The Society, with support from IMPACT/Namibia, arranged its first evening lecture on ART and PMTCT for the private sector in June 2003 in close coordination with the Ministry of Health. In March 2004, the Society organized a three-day continuous professional development seminar on HIV disease management and ART attended by 63 medical professionals. The Minister of Health and Social Services (pictured) stressed the importance of a strong partnership between the public and private health sector and congratulated the HIV Clinicians Society for their effort to establish a network of well-qualified health professionals providing clinical care for HIV. The HIV Clinician Society with support from IMPACT and the pharmaceutical industry held its first conference attended by more than 100 health professionals from across Namibia in April 2006. The HIV Clinicians Society has organized more than 40 trainings, evening lectures, and meetings for its members and other medical professionals; it has also been recognized as a technical partner by the medical insurance industry, the Namibian Association of Medical Aid Funds (NAMAf). As of April 2006, the Society had 180 paying members out of 700 practicing physicians throughout Namibia.



Implementing Agency:	LifeLine/ChildLine
Geographic focus:	Khomas, Erongo, Kavango, Oshana, Otjozondjupa, Omaheke, Karas, Hardap, Oshikoto, Omusati
Target population:	Vulnerable youth, OVC, PLWA, community members
Length of support:	February 1, 2002, to June 2006
Level of support	\$1,251,362

Organization Profile

Lifeline was founded in Namibia in 1980, and is part of **LifeLine** Southern Africa. LifeLine Southern Africa is affiliated with LifeLine International which has more than 200 centers in 12 countries, each operating independently. For 15 years, Lifeline Namibia provided mainly crisis counseling through its hotline, 14 hours/day, seven days a week, and staffed by lay counselor volunteers, trained in the Lifeline counseling curriculum. As the needs of the country changed, so did LifeLine, and in 1996 it merged with ChildLine, and started to focus on emotional health of children, as well as expanding its counseling services to include HIV and AIDS prevention.

Background

To address the issue of abuse and sexual violence against children, LifeLine/ChildLine implemented a child-focused program, *Feeling Yes, Feeling No*, in 1998 to complement its existing counseling and hotline services. The project aims to break the cycle of sexual abuse of children through a participatory program focusing on children of primary school age and involving adults, including committed teachers and parents. It teaches children how to keep their bodies safe from abuse and disease, and is supported by professional trauma counselors. These professionals provide in-depth therapy as well as referrals for rape and attempted suicide. Because of the growing need for counseling services, LifeLine/ChildLine also expanded its basic counseling training program to include HIV prevention and support counseling.

Accomplishments

During the four years of IMPACT/Namibia funding, the *Feeling Yes, Feeling No* participatory school program was expanded from three to 10 regions in Namibia, reaching more than 65,000 third- and fourth-graders and 2,100 teachers. A similar program aimed at older youth: “Being a Teenager” started at the end of 2005 and had reached more than 8,000 teenagers by June 2006. In support of the school program, IEC materials were developed in the form of “collector” cards. Eight messages focusing on human rights, and safety and protection of one’s body, such as: “Everybody has the right to say no, including you,” were produced as small collector’s cards like baseball cards, and children are encouraged to collect the complete set by swapping cards with their friends and school mates. Each school received a stand with 270 cards in the first round, with the “follow-up” cards distributed over an eight- to nine-month period. Approximately 100,000 cards have been produced and are in circulation in schools and libraries.

In support of the program, LL/CL launched their interactive weekly radio magazine, *Uitani*, on Katutura Community Radio (KCR) for young children.



Stephen Lewis interviewed by LL/CL Radio Program.
Photo courtesy of Lucy Steinitz, FHI.

The weekly call-in program is produced for and by children between 8 and 14 years of age. *Utani* explores how children deal with daily challenges and provides them with tools needed to cope with these problems by using the program as a vehicle for important life-skills messages. The call-in program is supervised by trained counselors. The program was co-supported by IMPACT/Namibia and UNICEF and is produced by LifeLine/ChildLine staff and volunteers, in collaboration with the College of the Arts and the Katutura Community Radio. This young, educational, informative, and entertaining show is broadcast in English in Windhoek every Saturday morning as well as on Sunday in several local languages, courtesy of the Namibia Broadcasting Corporation (NBC), which has a national reach.

In 2004, with technical assistance from IMPACT/Namibia, LifeLine/ChildLine's basic counseling training program was expanded to meet the growing need for support counseling for PMTCT and ART. Building on LifeLine/ChildLine counseling training experience, the curricula were revised and expanded to include four more training modules to respond to the growing need for trained lay people as community counselors to assist professional staff in HIV counseling and support services. FHI hired a clinical psychologist to work with LifeLine/ChildLine to develop a specific training methodology for "community counselors" to adapt the traditional approach to counseling to the specific needs of HIV-related services provided by an interdisciplinary team. This counseling approach provides a universal framework for HIV counseling that is applicable for a wide range of services from counseling and testing, through PMTCT and adherence. For each service, five steps are followed: 1) an assessment of the emotional state and general condition of the client/patient; 2) identifying key issues or problems and assessing their importance; 3) exploring options to address these issues; 4) agreeing on a plan of action with achievable objectives; and 5) organizing follow-up to continue the process. This client-centered approach enables counselors to focus on the whole person, putting HIV in the context of the client's life, not simply isolating their sexual behaviors, risk patterns, or treatment needs.

The training used a wide range of experiential and participatory learning exercises, discussion, practical examples, and role-plays to build the essential counseling skills. It also strengthened the capacity of service providers to deliver comprehensive services as an interdisciplinary team that optimizes the contribution of all team members, with the medical staff's primary focus on treating medical problems, and where the counselor concentrates on emotional and psychosocial support, as well as making sure the client understands important health-related issues, thereby supporting the client in any targeted behavior change such as risk reduction, adherence to ART, safe infant feeding or positive living. More than 500 people were trained in community counseling and subsequently posted at hospitals and AIDS service organizations across the country.

Implementing Agency:	Lutheran Medical Services (LMS)
Geographic focus:	Oshikoto and Oshana
Target population:	Pregnant women, PLWA, community members
Length of support:	October 1, 2003, to June 30, 2006
Level of support:	\$998,208

Organization Profile

Lutheran Medical Services (LMS) manages the Onandjokwe District Hospital. It presently operates on a not-for-profit basis, and is governed by the LMS Executive Committee, chaired by the Medical Superintendent of the hospital. At Independence, the Onandjokwe Mission Hospital became part of the government hospital system and is governed by an agreement signed by the MoHSS and LMS. The MoHSS and LMS contribute each 50% towards capital projects and the LMS receives 100% subsidy from the Government of Namibia to cover the running cost of the hospital. LMS works very closely with ELCIN, with pastors and volunteers providing spiritual and other support within the health services.

Background

LMS manages the Onandjokwe hospital in Oniipa (Oshikoto Region) serving a predominantly rural population of 200,000. The Onandjokwe Hospital provides preventive, rehabilitative, and curative services in rural areas. The hospital is responsible for the district in health matters and supervises health facilities in its catchment area, irrespective of whether they are managed by the MoHSS or religious denominations. Because of IMPACT/Namibia's experience with FBO's, the LMS and the Lutheran Church, were invited to participate in the discussion with USAID and CHS to develop a strategy to implement comprehensive PMTCT, and subsequently, ART to reach mostly rural and underserved populations in Namibia.

Accomplishments



PMTCT waiting room before the renovations

A major component of the IMPACT program was building the physical infrastructure of health facilities to ensure integrated prevention, care, and treatment services with adequate space for confidential CT and treatment at each facility. Preparing health facilities to deliver integrated services required extensive infrastructural upgrading and remodeling. The construction and renovations were critical for delivering high-quality care as well as to boost staff morale and to make facilities more user-friendly and provide one-stop services for ANC, CT, PMTCT, HIV, and OI treatment.

All efforts during the initial phase were focused on a rapid response to ensure the availability of trained staff and infrastructure as the anticipated demand for PMTCT and ART services would be high.

Centres were therefore designed to have sufficient space for waiting areas and circulation to facilitate patient flow within the building from reception to nurse/counselor, clinician, and pharmacy.

At the Onandjokwe Lutheran Medical Services Hospital, the installation of an integrated computer system increased access to relevant information by all staff caring for patients.



New waiting room

Providing high quality of services, including appropriate counseling and efficient patient flow, were considered essential to ensure high levels of adherence to ART and for continued success of the program. Health professionals, including community counselors, were recruited and trained using the national guidelines issued by the MoHSS. The training was a collaborative effort under PEPFAR, with clinical training for doctors and nurses provided by the Centers for Disease Control and Prevention (CDC)/International Training and Education Center on HIV/AIDS (I-TECH), community counselors training conducted by FHI/LifeLine/ChildLine, and VCT training provided by PSI/SMA. Routine laboratory services for CD4 count, HIV testing including Rapid Test, HIV DNA PCR and baseline blood test for HIV patients was provided through the Namibia Institute for Pathology (NIP) under its contract with CDC.

In April 2005, when the new Centre “Shanamutango” meaning “Let’s see who will be first” in the Oshiwambo language, was inaugurated, Onandjokwe had cleared its backlog and enrolled close to 1,000 ART patients; and by June 2006, more than 2,100 patients were on treatment for ART, including close to 500 children under the age of 15. PMTCT services started in the old building and from September 2003 through June 2006, just over 4,900 ANC women were counseled and tested for PMTCT plus services at the Centre.

VCT was provided at the hospital in concert with a local CBO who was responsible for pre- and post-test counseling. To ensure integration of counseling and testing within the centre, as well as to ensure computerized record keeping, IMPACT/Namibia extended the Shanamutango centre to include additional offices and consultation rooms for confidential counseling and testing as well as TB and OI services. The additional building was completed in November 2006 and the centre is now also providing counseling and testing as part of its integrated services.

Implementing Agency:	Rhenish Church
Geographic focus:	Hardap region
Target population:	Youth—OVC
Length of support:	April 1, 2005, to June 30, 2006
Level of support:	\$23,929

Organization Profile

The **Rhenish Church** was officially constituted in 1961 as an offshoot of the Evangelical Lutheran Church in the Republic of Namibia. It has 16 congregations and a membership of between 4,000 and 5,000, mostly in rural and underserved areas in the center and south of the country. The Church Synod decided in June 2000 to become actively involved in the fight against HIV/AIDS. However, it took until 2003 before the first congregation started its own AIDS program with initial funding from a UNAIDS Small Grant Fund.

Background

In 2005, the Rhenish Church became part of the Emergency Plan program, with support and technical assistance from IMPACT/Namibia. The program focused on increasing the awareness of youth on HIV/AIDS transmission and prevention; to ensure that young people at primary school level attended school and to ensure that young people between ages 10 and 25 abstain from sexual intercourse until marriage.

Accomplishments

IMPACT/Namibia funds enabled the Rhenish AIDS program (RAP) to provide support to six congregations, primarily in rural areas. The key achievements over 15 months of support were:

Outreach in congregations: Recognizing that most HIV/AIDS activities take place in urban settings, Rhenish focuses their outreach activities in the rural areas. Outreach began after a vehicle was purchased to solve transportation difficulties. An estimated 700 people were reached in these communities with abstinence and be faithful messages through personal contact by the OVC coordinator or through community meetings.

Support to OVC: Support focused on material support and psychosocial support. RAP registered 95 OVC with the Ministry of Gender Equality and Child Welfare and supported 60 with school uniforms. Another 35 children were taken on a weekend camp, 65 children were accommodated in Window of Hope programs (after school HIV-prevention programs initially developed through the Ministry of Education with UNICEF support and available to NGOs) and another 98 children were reached through visits to Sunday schools by the OVC coordinator.

Training of volunteers: Initially, twelve volunteers were trained to help with the implementation of the program. Maintaining the interest and involvement of these volunteers remains a challenge, as the Rhenish Church is unable to provide incentives. Towards the end of the project, two one-day workshops took place that educated 12 pastors and 35 elders of the Rhenish Church on basic facts on HIV/AIDS, and on how to recruit and support congregational volunteers.

Implementing Agency:	Ombetja Yehinga Organization (OYO)
Geographic focus:	Erongo region
Target population:	Youth in school
Length of support:	March 15, 2001, to December 31, 2004
Level of support:	\$124,193

Organization Profile

Ombetja Yehinga, meaning “Red Ribbon,” is a welfare organization created in December 2002, and officially launched in March 2003. Originally working the Kunene region, it expanded its activities to the coastal region of Erongo and Khomas, where Namibia’s capital city Windhoek is located. It aims to reduce the spread of HIV in Namibia by working creatively with young people both in and out of school to promote discussion and understanding of HIV and other social issues that affect them.

Background

Using art as a medium to provide relevant information about HIV/AIDS and related social issues, OYO specializes in the creation of IEC materials by young people for young people, including theatre and film. IMPACT/Namibia support focused on the implementation of the OYO project in the Erongo region. The project built capacity of teachers in HIV/AIDS and sexual health and developed behavioral change communication (BCC) approaches and materials adapted to the situation in the Erongo Region, targeting youth 12 to 25 years old.

Accomplishments

With support from IMPACT, OYO worked in 35 schools, trained more than 500 teachers, and reached 15,000 youth. In support of its activities, OYO published a quarterly magazine, by and for youth, and distributed in schools and beyond. Each of the seven colorful OYO magazines funded by IMPACT focused on a specific topic addressing an HIV or reproductive health-related issue, with most of the stories, poems, and drawings contributed by the youth. Through the AIDS clubs established at each of the 35 participating schools, students wrote songs, plays, and poems about HIV to reach young people. They participated in a series of role-playing exercises, which led to seven drama productions. Many of their plays were performed in their region and in the capital city of Windhoek. From these creative endeavors, short video films were produced using the students as actors, including “Love Can Cry,” five short film clips, each addressing an aspect of HIV/AIDS in Namibia. It highlights the choices available to young people to protect themselves, the role youth can play in raising awareness within their own communities, the tragedy of suicide, and the pain of losing parents to the disease. The film was launched in Windhoek and shown on national television for World AIDS Day in 2003. It was selected as one of 20 from 270 entries to be shown at the Pan African Film Festival in Burkina Faso. With support from IMPACT/Namibia, *Indiana Gowases (pictured)*, who acted in a clip about children orphaned by AIDS, was invited to represent the film and Namibia at the Burkina Faso festival.



Implementing Agency:	Philippi Trust Namibia
Geographic focus:	Hardap, Oshana, Khomas, Omaheke
Target population:	OVC
Length of support:	September 1, 2002, to June 30, 2006
Level of support:	\$301,213

Organization Profile

Philippi Trust Namibia is a nongovernmental organization established in 1996 that strives to provide the highest level of professional and accessible Christian counseling and counseling training to the churches and communities in Namibia. By 2001, looking at the growing orphan problem in Namibia, Philippi worked closely with churches to expand its counseling services to improve coping capacities of OVC through grief counseling and dealing with loss of loved ones. Philippi generates income by charging fees for their accredited counseling courses.

Background

Philippi Namibia believes that youth can play a major role in combating HIV/AIDS, and in empowering youth and orphans. In 2001, IMPACT/Namibia sponsored two Philippi staff to attend the First Regional Psychosocial Support Training in Zimbabwe to learn from, and bring back information on how to set up psychosocial support services in Namibia. CAA with assistance from Philippi conducted the first psychosocial training program for graduates of their home-based care program with support from IMPACT. Philippi realized the need to mobilize existing youth groups and churches to become involved in the tremendous problem of children orphaned by HIV. Adapting the Zimbabwe experiential learning module, and with support from IMPACT, Philippi developed a PSS training manual that is adaptable to specific audiences: e.g., adults, youth, or HBC workers. The project was initially co-funded by Secure the Future (BMS) and later by the Global Fund.

Accomplishments

With support from IMPACT, Philippi worked with young people through a diverse range of activities ranging from memory work, week-long experiential learning camps, fun and games, as well as psycho-social support through 14 kids clubs, supporting more than 2,000 OVC on a regular basis. During the camps and through the kids clubs group leaders work with children on issues of self-esteem, coping and grief, and reported a marked increase in self-esteem among the children in Kids Clubs. Kids Clubs provided a means for trained group leaders to reinforce the importance of attending school as well as monitoring school progress. The project trained 498 older youth as group leaders, 971 OVC benefited from week-long experiential learning camps, and 2,207 participated in supervised Kids Clubs.



Philippi with multidonor support, including FHI/Namibia hosted the first ever three-day children's conference where 50 OVC were given an opportunity to give feedback on the draft National OVC Policy and to work on their "Hero Book." Children explored their personal challenges, grief and joys to complete their book. The Hero Book is a form of psychosocial support through memory work. It is a book that invites the child to be an author, illustrator, main

character, and editor of the book that is designed to give them power over a specific challenge in their life. In the end, the child has a storybook of his or her own making that heralds and reinforces their hero-survival-resilient qualities. Philippi Namibia after many years of fund-raising inaugurated their own offices and training centre, with support of the Global Fund, land donated by the municipality, and private donations.

Below, Philippi Trust Namibia staff, group leaders and kids celebrating the launch of a new Youth Club.



Implementing Agency:	Sam Nujoma Ongwediva Multi-purpose Centre
Geographic focus:	Oshana
Target population:	Community, youth, OVC, workforce
Length of support:	April 1, 2003, to June 30, 2006
Level of support:	\$57,327

Organization Profile

The **Sam Nujoma Ongwediva Multi-Purpose Centre** was built by the Ongwediva Town Council in 2002 with assistance of its two sister-cities in Belgium. Funds from the USG Department of Defense provided additional space and a training room in 2005. The Ongwediva MPC is governed by a steering committee, which is chaired by the Mayor of Ongwediva. Its membership includes representatives from governmental and nongovernmental organizations, including FHI.

Background

The centre's mission is to provide a community- and youth-friendly atmosphere where people of all ages can feel comfortable, use the library, have access to computer training and Internet; and learn about health, environmental, and other issues affecting their community, including HIV/AIDS. The centre receives core support from the Municipality of Ongwediva and IMPACT/Namibia provided support for its youth, workplace, and OVC program, and coordinated with the US Peace Corps providing three volunteers tasked with capacity building.

Accomplishments

The youth outreach program used edutainment by and for youth, including music, drama, and sports, using themes that address societal problems such as drug and alcohol abuse, violence, sexual abuse, and rape; whereas the workplace and community program used health educators to promote safer behaviors. The Centre's OVC program focused on after-school care for 140 identified and selected needy OVC, with special emphasis on OVC from child-headed households. The after-school care program was supervised by a VSO volunteer, who in turn trained local volunteers. The after-school program includes supervised games, team sports, arts and crafts activities; life skills training—personal hygiene, social behaviors, and responsibilities, education/schooling, and healthy.

The centre's outreach program trained 164 people in peer and outreach health education, reached 7,711 learners in local primary and secondary schools with HIV/AIDS education and awareness activities, and more than 25,000 people in the community and surrounding area through special IEC events and awareness activities targeting various groups.

Implementing Agency:	TKMOAMS
Geographic focus:	Oshana, Omusati, Oshikoto, Ohangwena
Target population:	OVC, PLWA, community
Length of support:	October 1, 2004, to June 30, 2006
Level of support:	\$82,253

Organization Profile

TKMOAMS is a voluntary grassroots community-based organization that was formed 10 years ago by two employees of the Oshakati State Hospital, and works towards improving the lives of people living with, and affected by, HIV/AIDS in the rural north. TKMOAMS' mission is to contribute to a process of restoring hope and improving the quality of life for people and communities affected by HIV infection and disease through home-based care and by offering counseling, education, and training. In 2005 it became an NGO-registered with the MoHSS.

Background

TKMOAMS strength lies in their 700 volunteers, many of whom have worked for the organization for many years, usually without any incentives, providing HBC and support to OVC. Volunteers focus on the physical, psychosocial, and spiritual needs of clients and provide counseling, personal care, household assistance, referral with follow-up and spiritual care, and more recently have also started to function as treatment supporters for people on ARV medication. Volunteers and PLHA have several small income-generating projects—one for school uniforms and another for bead-making—and have been given several garden plots by local traditional leaders for the production of food.

Accomplishments

TKMOAMS was supported by IMPACT/Namibia, first under the Small Grants Program in support of an OVC School Uniform Project, and subsequently under PEPFAR, to strengthen their capacity to expand and to provide quality care services to PLHA and OVC. FHI collaborated closely with TKMOAMS' other main donor, Alliance 2015, (supported by Ibis (Denmark) and HIVOS (The Netherlands) to ensure a common strategy for training, supervision, monitoring and evaluation, and financial administration.

Because TKMOAMS was making the transition from a grassroots community collective to a more mature and multifaceted NGO, IMPACT staff provided regular consultation and in-depth technical assistance focusing on strengthening their management and leadership capacity via one-on-one mentoring; a review of internal policies and procedures, and through capacity-building workshops, including a workshop for the Board of Directors on Governance. In support of the capacity building activities, in early 2006, IMPACT/Namibia conducted an in-depth field assessment of TKMOAMS activities through a series of interviews and observations with volunteers to help determine priorities for the future.



TKMOAMS volunteers supporting a food project

There are currently 38 TKMOAMS community sites. Under the leadership of the community chairpersons, the volunteers reportedly visit clients at least twice a week (on average). They also meet monthly to update each other and to complete their activity reports that are taken to TKMOAMS office on a monthly basis. More than 90 percent of the volunteers were women and the majority was in their mid-50s and 60s. PLHA are among the volunteers and are part of the community support group. All group meetings and most home visits start and end with a prayer.

Home visits observed by FHI staff were characterized by openness, caring, and understanding. There are no signs of stigma and discrimination, particularly directed to PLHA. TKMOAMS runs one support group for PLHA that makes and sells beaded jewelry and handicrafts as an income-producing activity.

With IMPACT support, TKMOAMS trained six staff in psychosocial support, who in turn trained volunteers in 32 communities. Under the school uniform project (initially started under the Small Grants Program), 321 boys and 1170 girls were provided with school uniforms made by volunteers. Seven-hundred OVC received food three times a week at six soup kitchens operated by TKMOAMS volunteers, and 10 agricultural projects were providing food for PLWA and OVC.

Implementing Agency:	Walvis Bay Multipurpose Centre (WB MPC)
Geographic focus:	Erongo Region
Target population:	Youth, PLWA, workforce, community, high-risk groups
Length of support:	May 1, 2001, to June 30, 2006
Level of support:	\$585,497

Organization Profile

The **Walvis Bay Multipurpose Centre** first opened its doors in May 2001 through a joint effort of the Walvis Bay municipality and several US government agencies. The municipality of Walvis Bay donated the land, and three US agencies, the US Department of Defense (through the American Embassy), USAID, and the Peace Corps, formed a collaborative partnership to provide urgently needed community and youth-friendly services through this center, located in Kuisebmond, a high-density and previously disadvantaged area of the port city of Walvis Bay.

Background

FHI, under its IMPACT cooperative agreement, was tasked with the management and capacity building of WB MPC. During the first four years of the project, the centre was managed by the FHI office in Windhoek, with the centre's director reporting to the FHI country Director. During this period, FHI Namibia staff, assisted by three successive Peace Corps volunteers, as well as two VSO volunteers, built the capacity of the centre's staff and volunteers in program and financial management, resource development, report writing as well as the development of a strategic plan. Technical capacity building focused on HIV prevention, care and support, computer literacy, and community mobilization.

In addition to the WB MPC staff, Catholic AIDS Action and Population Services International (PSI) were provided offices in the centre, the former providing home-based and OVC care, with the latter providing condom social marketing and outreach to high risk groups. The original building quickly outgrew its capacity, both in terms of office and training space, as the centre's funding and programs increased and additional staff and volunteers joined. In 2003, with funding from the EU through PSI, the center added a VCT centre, whereas CAA raised money from the church to build its own offices on the premises.

Accomplishments

As part of the capacity-building effort, the Walvis Bay MPC was registered as an Independent Trust with the High Court on May 31, 2004, and governed by a board of directors. As of June 2006, the centre employed 27 staff and their present services include a "fee for services" workplace program, outreach to the community and schools, VCT services with referrals to the Walvis Bay PMTCT and ART clinics, while HBC and OVC care and support services are continuing through CAA.

The youth-friendly atmosphere of the WB MPC continues to provide a venue for after-school kids clubs where peer educators facilitate the popular Windows of Hope program and school holiday programs for children from the Walvis Bay and surrounding areas. The school holiday program, drama and cultural groups, and computer training attract large numbers of young people to the centre. The WB MPC youth edutainment program, once co-funded by the Elton

John Foundation and managed by FHI/Namibia, has outreach programs to all schools in the Walvis Bay District, using young trained volunteers and people living with HIV/AIDS to convey messages on prevention, care, and support to learners and teachers through song, drama and quizzes. Close to 100 volunteers were trained, who on average reached 8,000 learners a year.

The workplace program of the WB MPC focused on the private sector as well as the municipalities of Walvis Bay and Swakopmund. They have worked with 25 companies through their “fee for services” program and trained more than 100 peer educators, who in turn educate on average 6,000 workers each year. The program consists of an initial 25-hour training to



develop the skills necessary to share accurate, up-to-date information in their workplace. The WB MPC workplace team works very closely with each Human Resources Department to ensure buy-in and support, and all employees are encouraged to attend sessions, which are offered in any of the three languages Afrikaans, English, and Oshindonga, using the peer educator materials jointly developed with FHI and other implementing partners.

MPC Health Educators working at one of the fishing companies

Workplaces are also encouraged to set up condom-distribution systems within the workplace, and can also buy or borrow videos from the MPC to assist with specific topics such as counseling, VCT, or PMTCT. In addition to reaching workers in their place of work, the MPC team also conducts weekly evening sessions in Shebeens, frequented by locals as well as long-distance truck drivers, fishermen and sailors, reaching more than 2,000 bar clients a year.

Over the life of the project, more than 100,000 condoms were distributed free of charge at the centre, and through its workplaces and shebeens activities.

ATTACHMENTS

Appendix I

Country Program Financial Summary

Total IMPACT funds		\$	19,524,935
FS-HIV	\$	3,074,000	
EDDI	\$	1,400,000	
RUDO	\$	52,000	
PEPFAR	\$	14,998,935	

Subagreements/contracts with local IA's (including equipment procurement)

Number of Implementing partners	27
Number of contracts for infrastructure with architects/builders	13
Number of subagreements/contracts	58
Total amount of subagreements/contracts including procurement	\$ 13,155,677
Medical procurement on behalf of partners (drugs)	\$ 313,291
Printing of curricula and educational materials	\$ 146,696
Workshops/trainings for or on behalf of partners	\$ 176,754
Percentage of total funding	71%

Program Management Support and Technical Assistance

Technical Assistance: Capacity Building/M&E/Program Management (Includes FHI/Namibia, regional, and head office support)	\$ 5,732,517
Percentage of total funding	29%

Appendix II: FHI Namibia Materials, Reports, and Publications

First National Conference on Orphans and other Vulnerable Children, Windhoek, Namibia 8-10 May 8–10, 2001. Full Report, funded by the Government Republic of Namibia, UNICEF, IMPACT/Namibia and USAID.

Caring for People living with HIV and AIDS, Windhoek, 2001. The Namibian with support from IMPACT/Namibia and UNESCO.

Second National Conference on Orphans and Other Vulnerable Children: “Facing Challenges, Ensuring Futures.” Windhoek, Namibia, June 25–27, 2002, Full and Summary Reports, funded by the Government Republic of Namibia, UNICEF, and IMPACT/Namibia.

How Should We Care for our AIDS Orphans? Windhoek, 2002. The Namibian, with support from UNESCO and IMPACT/Namibia.

Meeting on African Children without Family Care, Windhoek, November 30, 2002. Final Report, IMPACT. A workshop organized in conjunction with the Eastern and Southern Africa Workshop on Children Affected by HIV/AIDS, Windhoek Namibia, UNICEF and FHI/IMPACT.

Impact Assessment of HIV/AIDS on the Municipalities of Ongwediva, Oshakati, Swakopmund, Walvis Bay and Windhoek, 7 volumes, SIAPAC with support from IMPACT/Namibia, Windhoek, February 2003.

Report of the NALAO Capacity Building Workshop and Plan of Action, (10 municipalities) SIAPAC, July 2003, with support from IMPACT/Namibia.

Facility Assessment of five faith-based hospitals, 2004, FHI/Namibia.

Building Resiliency Among Children Affected by HIV/AIDS, Catholic AIDS Action, June 2002. Revised publication (2004) in Afrikaans and Oshindonga was supported by IMPACT/Namibia.

National Plan of Action, 2004, funded by UNICEF and USAID (with partial technical support of IMPACT/Namibia).

National Policy on Orphans and Vulnerable Children, Ministry of Women Affairs and Child Welfare, December 2004, with support from UNICEF and IMPACT/Namibia, including translation and distribution in six languages.

Third National Conference Orphans and Vulnerable Children: “Are we meeting the needs of our OVC?” Windhoek, Namibia, February 9–11, 2005, funded by the Government Republic of Namibia, UNICEF, and IMPACT/Namibia.

National Monitoring and Evaluation Plan, 2006, funded by UNICEF and USAID (with technical support of FHI/IMPACT/HQ).

Training and BCC materials developed and/or produced

- Training of Trainers Peer Education Manual, IMPACT/Namibia 2003.
- Peer Educator Practical Handbook in three languages English, Afrikaans and Oshindonga: A 12-session manual covering prevention, care, and treatment of HIV and AIDS, IMPACT/Namibia 2004, revised 2006.
- PMTCT booklet in three languages English, Afrikaans and Oshindonga, FHI/Namibia 2004, revised and reprinted in collaboration with PSI/SMA, Namibia 2005.
- Peer Education Flipchart (English, Afrikaans, Oshindonga), FHI/Namibia 2004: Large, colorful IEC flipcharts, illustrating HIV/AIDS prevention, care, and treatment issues, revised 2006.
- OVC Monitoring Toolkit, OVC Toolkit, 2003 Namibian Resource Consultants, with support from IMPACT/Namibia.
- Kauna's Birthday Wish, Lucy Y. Steinitz, Catholic AIDS Action, Windhoek, 2003. Translated into Oshindonga and Afrikaans. Supported by FHI, UNICEF and USAID.
- HIV/AIDS in the Workplace (guidelines for employers, employees: facts, laws, rights) AIDS Law Unit, LAC, 2004, with support from FHI/USAID in English, Afrikaans and Oshindonga
- Making it Happen: A guide to help your congregation do HIV/AIDS work, Lucy Y. Steinitz, 2005, (Strategies for Hope, Called to Care Series no.2, UK, co-published with Family Health International).
- Planting the Seeds of Board Development: Helpful Hints and Suggestions on Growing your Board of Directors, FHI/Namibia, 2005.
- The Art of Super-VISION: A compilation of Tips and Ideas—A manual exploring different approaches and strategies to effective supervision, FHI/Namibia, 2005.
- Psychosocial Training of Trainers Curriculum CAA and Philippi—English, Afrikaans and Oshindonga, 2004.
- Psychosocial Support Training for Caregivers, Windhoek 2005. Philippi Namibia, with support from UNESCO, IMPACT/Namibia, Global Fund.
- Ministry of Gender Equality and Child Welfare: Child Welfare Grants, in six languages with support from IMPACT/Namibia.
- The Rights of OVC and their Caregivers, Legal Assistance Centre, Windhoek Namibia, with partial support from IMPACT/Namibia.
- Treatment Literacy Brochure, Legal Assistance Centre, Windhoek Namibia, with partial support from IMPACT/Namibia.
- Community Counseling Toolkit: consisting of 6 modules, 13 volumes. IMPACT/Namibia and LifeLine/ChildLine, Windhoek 2006.
- The *YouthPaper* produced weekly by *The Free Press of Namibia*, with partial support from IMPACT/Namibia, Windhoek, April 2001–September 2006.
- OYO quarterly magazine for Youth focusing on reproductive health, HIV prevention and care, stigma and discrimination, rights and policies (7 editions 2003–2004 supported by IMPACT/Namibia)

IMPACT/Namibia Staff and Implementing Partner Presentations at International and Regional Conferences

July 2002: XIV International AIDS Conference, Barcelona, Spain

- “FHI/USAID- and UNICEF-Supported OVC Program in Namibia.” Ms. P. Masabane, Ministry of Health and Social Services, Namibia.
- “The Comparison of Impact Projections and Actual Data on HIV and AIDS in Namibia.” Dr. Fred van der Veen, FHI/Namibia.
- “The Value of Multi-Purpose Centres in a community to reduce the impact of HIV/AIDS.” Beverley Figaji, FHI/Namibia.

July 2004: XV International AIDS Conference, Bangkok, Thailand

- “A National Model of Integrated Psychosocial Support for Orphans and Vulnerable Children in Namibia.” Ministry of Gender Equality and Child Welfare.
- “Antiretroviral Treatment in the Private Health Sector in Namibia.” Poster presentation, Dr. Fred van der Veen, FHI/Namibia.
- “A Grassroots Methodology for Monitoring and Evaluating OVC Programs.” Poster presentation, Francis van Rooi, CAA/Namibia.

December 2005: ICASA, Abuja, Nigeria

- “The Role of Faith-Based Organizations in the Fight Against HIV in Namibia.” Lucy Steinitz, FHI/Namibia.

June 2006: PEPFAR Conference, Durban, South Africa

- “Factors Associated with defaulting HAART in Rehoboth District Mission Hospital, Namibia: Programmatic Challenges.” Dr. Kangudie, Catholic Health Services.
- “The Private Health Sector as a major contributor to achieving Namibia’s Antiretroviral Treatment target.” Dr. van der Veen, FHI/Namibia.
- “Beyond VCT: A Novel Approach to Counseling of Clients and Patients with HIV.” Poster presentation, Lisa Fiol Powers, FHI/Namibia and Amanda Kruger, LifeLine/ChildLine.
- “The Role of the HIV Clinicians Society in the Roll-out of ART in Namibia.” Poster presentation, Dr. Flavia Mugala, HIV Clinicians Society.
- “Integrated Services for People with HIV Require Integrated Clinical Management Systems: Experience of a Public-Private Partnership in Namibia.” Poster presentation, Dr. Fred van der Veen, FHI/Namibia.

Appendix III: Case Studies

Above and Beyond the Call of Duty

Agnes Sikwela doesn't know exactly when she was born, but she estimates that she is about 85 years old. She also says that she never imagined that in her old age she would still be taking care of young children. But that is her situation; instead of others taking care of her, she is responsible for eight grandchildren and great-grandchildren whose own parents, her own offspring, have since died.



Poverty and hunger are common companions for Agnes Sikwela and the orphans under her care. Until recently, they didn't have decent shelter either. Agnes Sikwela's mud-and-straw hut was falling apart, forcing everyone to sleep outside. In the summer they were hot and became easy prey to insects, vermin, and petty theft. In the winter, they were cold and subject to illness.

Without shelter, Agnes Sikwela said, she felt that her family was drifting apart. And if that happened, she worried, what would happen to the children?

Good fortune shone on Agnes Sikwela and the children for whom she cares. The newly trained volunteers of Catholic AIDS Action in the Kabbe village, Caprivi Region, learned of the old woman's plight. These volunteers received their training and support from the US President's Emergency Plan for AIDS Relief, through Family Health International under its cooperative agreement with USAID. Although their training focused on home-based care, counseling, and prevention education, the volunteers decided that the most important thing they could do for Agnes Sikwela was build her a new house. They organized themselves, pooling their own resources, to build new walls, a new roof and a door. The photo above shows Agnes Sikwela in front of her new house, together with some of the volunteers and children under her care. Life is still very difficult for this family, but with a new home, they have a chance for a better future.

Finding Friendships, Knowledge, and Personal Strength

“I found many friends, here,” young Timothy said after a week long experiential learning camp for orphans and vulnerable children run by *Philippi Trust Namibia*, “But most of all, I found out that God is my friend. He made me special. I also found out that I can do things I never thought I could do before, and that I am strong, even though I am still very small.”



Other campers shared similar messages. Among the adults present in the room, there was scarcely a dry eye. This occasion marked the close of a holiday-camp by Philippi Trust Namibia for 74 campers drawn from churches, informal settlements, and orphanages in the Khomas and Hardap regions. It was also the graduation of 26 group leaders, all in their late teens and 20s, whose two-week training spanned both theoretical issues and practical experience.

“We often speak about these children as being the future of the nation,” explained Kaino, one of Philippi Trust Namibia’s leaders at the graduation. “But unless we help them gain the skills and the confidence that they can take a leadership role to build a meaningful future, how is that going to happen?”

Participants ranked what they liked best at the camps. Coming out on top were: making new friends, playing various “trust games” (designed to restore their self-confidence and relationship skills), learning more about HIV/AIDS, understanding how they can protect themselves for a more secure future, proper nutrition and spending time with their group leaders which guide them and provide support.

Herlyn's Story

Many of the youth volunteers trained by the Walvis Bay Multi-Purpose Centre (WB MPC) became fulltime staff members and several found employment with other NGOs or the private sector. Herlyn, a young HIV-positive woman, worked for many years as a volunteer, and became a full-time staff member under the Independent Trust. Herlyn has a message of hope, and she is bringing it to her community. She wants them to know that they do have options in life, and a wealth of resources available to help them overcome this pandemic. "I know that change does not come quickly or easily," admits Herlyn, "but I do know that one person can make great changes with their attitude." Herlyn has overcome the most difficult of life's challenges. At the age of 16, she was diagnosed with HIV but refused to become complacent about her condition. At the age of 18, she shared her experiences with students at the Kolin Foundation, publicly revealing her HIV status for the first time. It proved to be a life-altering experience. Herlyn made a decision to devote her life to AIDS prevention work and joined the Walvis Bay Multi-Purpose Centre as a volunteer, where she trained as a health educator and became the "positive" face for community outreach and workplace interventions.

Herlyn's positive attitude and communications skills were further developed through training in basic counseling, which led her to specialized courses CT, PMTCT and HIV treatment adherence, organized by LifeLine/ChildLine, with support from IMPACT/Namibia. The counseling training is client-centered using a wide range of experiential and participatory learning exercises, discussion, practical examples and role-plays to build the essential counseling skills. The training program, through its six-module toolkit, has trained more than 500 community counselors for both the public and NGO/FBO sectors, including Herlyn and other staff at the Walvis Bay Multi-Purpose Center. At the Center, Herlyn has made landmark contributions as a community counselor at the New Start VCT centre, but also through the Centre's Ladies First Outreach Program, where she together with five other HIV-positive volunteers reached more than 8,500 community members by going from door to door, surveying people on their HIV knowledge, and by conducting awareness sessions in private homes, talking mostly to women about HIV prevention and care; and encouraging them to come to the Centre for CT services.



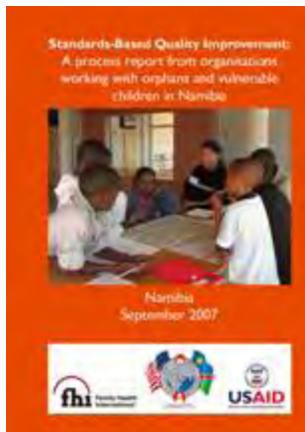
Herlyn counseling a client - Photo credit: Ralph Hoeflein, Windhoek

Presently, Herlyn is the post-test club counselor and coordinator for the Centre's two HIV positive support clubs, meeting one afternoon once a week. According to Saima, the Outreach Health Educator, Herlyn's success is due in part to her fluency in several languages and her personal forthrightness. "She is open with her status and she is approachable in the community. Some of the community members now feel comfortable disclosing their status to her more than with any other volunteer."

Improving and Assuring Quality Services for Orphans and Vulnerable Children

FHI/Namibia was at the forefront of the development of “Improving and Assuring Quality Services for Orphans and Vulnerable Children” when in 2006, USAID Africa Bureau through IMPACT facilitated a process for partners working with orphans and vulnerable children to develop a shared set of outcomes and standards of practice for service areas for quality improvement and assurance. This included reaching an agreement on minimum characteristics in seven key domain areas (psychosocial support; education support, protection, shelter and care, health, food and nutrition, and economic strengthening/opportunity).

Over the course of several months consultations were held with a number of key implementing partners, the Government of Namibia as well as nongovernmental and faith-based organizations working with vulnerable children funded under PEPFAR. This resulted in a document entitled “*Outcomes and Quality Standards for Core Services: An initial guideline for partners in Namibia working in support of orphans and vulnerable children.*”



This was followed a few months later by in a Namibia-based publication as the first country to implement this process beyond the initial stages. That publication, written by the FHI-Namibia team, is called, *Standards-Based Quality Improvement: A Process Report from Organizations Working with Orphans and Vulnerable Children in Namibia*. The Namibia process spanned approximately one year, and involved a series of workshops and on-site assessments. Towards the end of the process, three implementing partners, Catholic AIDS Action, Philippi Namibia, and Kayec, applied the tools in the report in their own on-site Quality Assurance and Improvement (QAI) review of each others after-school programs. As a result, each implemented several changes to ensure the children’s safety, improved psychosocial support, and educational services.

The FHI Namibia team also co-facilitated the pilot introduction of this work in Ethiopia and Zimbabwe, as well as in an international training-workshop on QAI with participants from 17 countries that was held in Tanzania in September 2007. The Tanzanian workshop was organized by the Office for Sustainable Development in USAID’s Bureau for Africa with assistance from FHI, the University Research Corporation, PACT, and the International HIV/AIDS Alliance.

The workshop in Ethiopia involved adults who represented PEPFAR partners. But it was soon realized that those most affected by orphaning—the children themselves—would provide invaluable input for workshops on quality standards and outcomes for services designed for their benefit. Their participation would also advance the PEPFAR mandate that orphans and other vulnerable children be actively involved in determining their own future.

Accordingly, the workshops in Zimbabwe and Namibia centered on this goal. They engaged between 16 and 35 youthful participants from diverse backgrounds and evenly divided by gender. Several children with severe disabilities joined the group in Zimbabwe and “contributed

enormously to the experience.” Given the insecurities and challenges already experienced by these young people, planners ensured that the workshops were held in secure settings and included adult chaperones.

One highlight of Namibia’s work has been the direct involvement of children in designing these standards, which has been documented in the two reports and on a training film. When introducing themselves, the youngsters were asked to mention something they were proud of, and the facilitators wove this recounting into their descriptions of the seven core service areas. A “River of Life” exercise was another interesting feature of the workshop: participants were asked to chart the ups and downs of their short lives to date and express their hopes for the future.

USAID/Namibia’s OVC Technical Coordinator Gabriel Kalungi acknowledges the excellence of



FHI’s technical assistance: “This relationship between FHI and the OVC is like that of a good mother to her children. FHI staff members have incredible knowledge, skills, and attitude, which are ideal for mentoring those who are junior in the OVC field... FHI was instrumental in a big way, and in the role that involved the children and youth to provide their input in the draft of the quality standards.”

Lejeune Locket, Peace Corps Namibia with youngsters