

Volume 2: Ongwediva

Impact Assessment of HIV/AIDS on the Municipalities of Ongwediva, Oshakati, Swakopmund, Walvis Bay and Windhoek

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for

**the municipal authorities of
Ongwediva, Oshakati, Swakopmund, Walvis Bay and Windhoek,
on behalf Family Health International (FHI) and USAID/Namibia**

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ALAN	Association of Local Authorities in Namibia
ASO	AIDS Support Organisation
ARV	Anti Retroviral
EAP	Employee Assistance Programme
EPZ	Export Processing Zone
FGD	Focus Group Discussion
FHI	Family Health International
GDP	Gross Domestic Product
GRN	Government of the Republic of Namibia
HEARD	Health Economics and HIV/AIDS Research Division
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
KAP	Knowledge Attitudes and Practices
KII	Key Informant Interview
MOHSS	Ministry of Health and Social Services
MRLGH	Ministry of Regional and Local Government and Housing
NALAO	Namibia Association of Local Authorities Officers
NISER	Namibia Institute for Social and Economic Research
NEPRU	National Economic Policy Research Unit
NGO	Non Governmental Organisation
PLWA	People Living with AIDS
SADC	Southern Africa Development Community
SIAPAC	Social Impact and Policy Assessment Corporation
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SWAG	Story with a Gap
USAID	United States Agency for International Development

Executive Summary

Introduction

Namibia has one of the highest rates of HIV infection in the world, and the epidemic is affecting every aspect of Namibian society. The impacts of the epidemic include a reduction in the population growth rate, alterations to the demographic structure of the population, economic losses through a reduction in Gross Domestic Product (GDP), as well as changes in society at large.

Namibia has based its response on the need to involve all sectors, and it is local authorities, as the level of government closest to the people, that play a key role.

However, the ability of local authorities to respond to the epidemic is undermined because it takes place within the context of the epidemic's direct impacts *on local authorities as well*. Municipalities and councils will lose personnel to the epidemic, due to illness, death, or responding to the illness and deaths of family members. Further, HIV/AIDS increases the costs of doing business, effectively undermining efficiency and reducing turnover, with negative impacts on employment potential and the creation of revenue.

As part of their key role in responding to the epidemic, five Namibian municipalities requested support to commission assessments to determine impacts and plan their responses to the challenge. This initiative signalled one of the world's first local authority impact assessments, and the municipalities deserve credit for their foresight. Specifically, this investigation considered the impacts on the five Namibian cities of Ongwediva, Oshakati, Swakopmund, Walvis Bay, and Windhoek. This volume presents the findings for the city of Ongwediva.

HIV/AIDS

Antenatal sero-surveillance surveys are routinely used to measure adult HIV prevalence and are undertaken in Namibia by the Ministry of Health and Social Services (MOHSS). All prevalence data in this report are based on these surveys. The last such survey completed by MOHSS was in 2000. Unfortunately, Ongwediva is not included in the surveillance sites, and therefore the prevalence rate for the town is unknown. However, Ongwediva is less than 6 kilometres from Oshakati, and its prevalence rate of 28% was therefore used. This is almost 6% higher than the national rate of 22.3%, and, together with Walvis Bay, Ongwediva and Oshakati have the third highest prevalence of all the sites surveyed by the MOHSS in Namibia, after Katima Mulilo (in Caprivi region) and Windhoek. The implication is that over one quarter of the adult population in Ongwediva (those aged 15 and older) are now likely to be infected.¹ Based on current modelling, HIV prevalence in Ongwediva appears to be very close to its peak. If the epidemic continues to follow past trends, HIV prevalence will peak at 30% by 2003/4. However, there is no reason to assume that it will indeed peak as projected, other than this is what the Namibian-accepted model says. Indeed, Namibia may follow Botswana's example and have rates of up to 50%. This suggests that there will be a need to update model findings as new data become available.

The data presented in this Assessment are based on projections derived from models of the demographic impact of HIV/AIDS on the general population. The assumptions used to develop the models are fully discussed in Volume 7. It is important to note that the assumptions used are based on official Ministry of Health and Social Services and Central Bureau of Statistics data, and were discussed and agreed at progress meetings held with municipal officials prior to their incorporation in the model.

¹ Antenatal surveillance is routinely used to measure adult HIV prevalence. This fact is often hotly debated, with the belief often that it over-estimates prevalence. Studies elsewhere in the region indicate that, particularly earlier in the epidemic, antenatal prevalence does roughly equate with adult prevalence in the general population. As the epidemic matures, however, it may become an *underestimate* of adult prevalence, as HIV reduces fertility.

The projections indicate that some 1,500 people are presently estimated to be HIV-positive, or an estimated 16% of the town's population. This will rise to 2,000 individuals by 2012 and slightly under 2,400 in 2021.

The data further suggest that an estimated 450 people in Ongwediva have died as a result of AIDS. By 2010 the figure is likely to be closer to 2,050 individuals. The 1,600 AIDS deaths expected between now and 2010 are largely unavoidable, because these will result from existing HIV infections. However, it is extremely important to note that many of the projected deaths from 2010 onward could be avoided *if* future HIV infections can be reduced. By 2021, cumulative AIDS deaths are expected to exceed 4,000, *but many of these can be avoided.*

AIDS deaths can be reduced by implementing prevention programmes, including those that encourage destigmatisation, wellness and positive living for those infected and, should this become more widely available in Namibia, through treatment.

Population Growth

Despite the HIV/AIDS epidemic, the projections indicate that Ongwediva will continue to grow, but at a slower rate, mainly because of continued inward migration from other areas in northern Namibia.

The population of the town is presently estimated to be some 9,000 people (2002), but this number would have been higher in the absence of AIDS. By 2021, in the absence of AIDS the population of Ongwediva would be an estimated 19,000 people. However, the epidemic is expected to result in a population of some 12,000 people by 2021, over 36% lower than it would have been without AIDS. This will have implications for the town's planning, service delivery and revenue growth.

The socio-economic impacts of HIV/AIDS on Ongwediva are therefore likely to be severe. This is because of the number of deaths, because those who are dying are in the productive or working age groups and because these are the workers and parents serving the community.

Economic Impacts

The Oshana Region is very vulnerable to the economic impacts of HIV and, as Ongwediva's economy is linked to and supported by the region, it too is vulnerable. Efforts to attract investment will be affected, as many investors are reluctant to establish enterprises in areas where HIV prevalence is high because of personnel replacement costs and constraints on purchasing power.

As stated previously many households in the region rely on subsistence agriculture and small enterprises for their livelihoods, and the loss of labour at key times in such a labour intensive environment can be devastating and have major implications for the community. If households suffer a fall in agricultural production, that production is lost to the entire community.

The importance of cash remittances in the local economy creates further vulnerability. It has been widely argued that migrants are at high risk of infection. Their illness and loss of earnings affects themselves and the households they remit to and income is likely, therefore, to be reduced within the entire community.

When income is reduced not only for the household, but for the region as well, there is a ripple effect. Households that lose income are no longer able to spend at previous level, this affects the income of shopowners and in turn producers in the region and has, therefore an amplified impact on the community. In Ongwediva this means that the household impacts in the surrounding areas will have a detrimental affect on the retail and service businesses in the town.

Retailers and producers will, therefore, be affected in different ways and as businesses are impacted, productivity declines and further jobs are lost. The economic impacts of HIV will, therefore, be felt not only by those infected but also by the entire community.

Orphans

HIV/AIDS profoundly affects families and communities, not only resulting in the loss of labour and assets, but also affects socio-cultural skills while placing almost unprecedented stress on community and extended family networks. One of the most serious consequence of the epidemic is the increase in the number of orphans. It is estimated that there are already over 250 children in Ongwediva who are currently under the age of fifteen and have lost one or both parents as a result of AIDS. This number is expected to increase to almost 1,300 in the next 10 years. The ability of community to absorb and care for children who have lost their parents will be strained by this rapid increase in orphans. It is, however, important to note that these figures may be an *over-estimate* of the scope of the orphan situation in Ongwediva, as children orphaned in Ongwediva may be sent to extended family members in rural areas in the north. Alternatively, it may also be that orphans come from the western and central regions of Namibia, and may be sent to extended families in Ongwediva.

Impacts on Ongwediva Town Council

These impacts will result in demands from the community for expanded or new services to be provided by local authorities and a lowered ability to pay for these services. However, municipalities are not isolated institutions and will not be immune from the impacts of the epidemic. These impacts result from the sickness and death of municipal personnel infected with HIV, and can include:

- loss of productivity;
- increased absenteeism;

- cost of sick and compassionate leave;
- increased cost of benefits; and
- increased recruitment and training costs to replace lost staff members.

The challenge is that the epidemic erodes the ability of institutions, including local authorities, to provide services, as it reduces *both* efficiency and revenues, while the personnel losses induced by HIV/AIDS affect the quality of services the Town Council is able to provide.

It is important to understand that HIV-infection precedes AIDS illness and death by some eight to ten years. In other words, the AIDS mortality presently being experienced within the Town Council results from HIV-infections acquired some six to eight years ago. The full impact of AIDS on the municipality is therefore only likely to be felt between 2008 and 2010 when the numbers of those falling ill and dying will reflect the town's current high prevalence rate. The period 2001- 2012 was therefore selected for projecting the impact of HIV/AIDS on these employees because, while current infections cannot be prevented, it was assumed that *immediate* prevention activities would be put in place to reduce those in future.

In 2001, Ongwediva Town Council employed some 59 individuals. Over the period, 2001-2012 some 26 staff across all staff grades to AIDS are projected to die from AIDS-related illness, provided staff numbers remain the same. AIDS deaths among Council staff are projected to continue to rise from 1 death in 2002 to 3 in 2009, remaining at this level until 2012.

These levels of AIDS mortality will impact on the Council through increased absenteeism (sick and compassionate leave), productivity losses and increased replacement and training. Each of these impacts will have associated costs and will therefore require management and mitigation, with particular attention being paid to the financial and human resource management implications.

Human Resources Management Information System

Ongwediva maintains human resource records and data, and was able to provide the Consultants with much of the personnel data needed to complete this Impact Assessment. However, at the outset it is important to note that refinement is needed to improve the type of data that should be provided to managers on a monthly basis enabling them to monitor and manage the impact of the epidemic internally. Leave data should be collected monthly, by type and length of leave taken by grade of staff (i.e., whether sick, vacation, compassionate, or bonus leave, etc.). The costs of this leave (by type and grade) also need to be calculated monthly.

Leave

The amount of sick leave taken by staff because of AIDS-related illness is one of the main costs of the epidemic to any employer. Ongwediva Town Council employees are entitled to 120 days sick leave at full pay over any thirty-six month period, which can be extended by 120 days of sick leave at half pay over a thirty six month period.

Over the period 1999-2001, the number of staff taking sick leave increased from 9 individuals taking 23 days off in 1991 to 15 staff who took 159 days of sick leave in 2001, without any substantial increase in staff numbers. The epidemic will increase the amount of sick leave taken by Council workers. Analysis indicates that the number of days off taken by municipal employees *as a result of AIDS* will increase from an estimated 200 days in 2002 to some 400 days per year over the period 2008 - 2012. Obviously, the costs of this will be high and programmes that encourage positive living and wellness could assist in reducing these.

Benefits

Among the benefit entitlements of employees of Ongwediva Town Council are medical aid and pension contributions. In both cases monthly contributions by the municipality can be expected regularly to increase because of the epidemic.

Membership of a medical aid plan is voluntary for employees of the municipality. Where employees are members, the municipality pays 50% of the employee's monthly contribution. In 2001 these payments amounted to N\$1.8 million. The cost of medical aid to Council and to its employees is rising as the number of those requiring AIDS medication increases.

Similarly, employees of the Town Council are members of the Retirement Fund for Local Authorities in Namibia. This Fund operated as a defined benefit fund until 1992, when due to the large number of claims it changed to a defined contribution fund. This means that the amount paid to members' families on their premature death was reduced. The current death benefit allows for a lump sum payment of 5.3 times annual salary at the death of a member, with three differing options based on the level of guarantee and investment. The impact of HIV/AIDS has already caused the funds to lower the death benefits and to increase the cost to the members. This trend will continue as more members die from the diseases associated with AIDS and death benefit claims continue to rise.

Training

Council provides training to staff, subject to its policies. HIV/AIDS will increase the need for training of personnel, as employees are lost to the epidemic early in their careers. Equally, the private and other sectors, which may offer higher salary and benefit packages, may increase the rate at which they 'poach' trained staff as they lose employees. This, in turn, will increase the costs of training as it further increases staff turnover. Council training policies therefore need to include strategies for maintaining and developing skilled staff. These have to be based on the provision of more frequent but shorter-term training opportunities, within affordable cost parameters.

Critical Functions

Some of the institutional costs associated with HIV/AIDS can be identified and with some difficulty quantified. Many, however, are more difficult to determine and these less obvious

costs and consequences may be larger and more important. These include the loss of institutional memory, the impact on staff morale, and the inability to perform critical functions.

In Ongwediva, managers were most concerned about their strategic management and planning functions. Managers, however, indicated that while the Council would suffer as it would not be able to manage the epidemic and build capacity simultaneously, the fact that it was small has advantages as many of the line managers are capable of standing in for one another.

Costs

For Ongwediva, the main costs will lie in increased absenteeism, medical aid contributions and productivity losses. Over a nine year period (2002 - 2010) the present value cost solely due to the HIV/AIDS epidemic will be **N\$565,230** across all bands. The following table provides data on these increased costs by band. The figures are discounted totals (i.e., are shown at present value):

Table ES1: Total Increased Costs Resulting from the Epidemic by Band, Ongwediva Town Council (2002 - 2010)

Band	2002	2003	2004	2005	2006	2007	2008	2009	2010
All Bands	65,749	62,805	59,963	57,192	54,510	64,604	70,107	66,744	63,556

However, the internal costs arising from the impact of HIV/AIDS on municipal personnel are not the sole economic impact of the epidemic. The performance of the economy and the growth rate of the town may affect the level of demand for municipal services. There must also be concern as to the ability to pay for most services as a result of constrained household economies resulting from HIV/AIDS. Electricity provision is, however, different. It is likely that overall electricity sales will be related to the performance of the town and regional economy. Any factor, such as AIDS, depressing the growth of the economy will depress the growth in demand for electricity and revenue generated from the Council's shareholding in the distribution company.

Further, while household ability to pay for services will be constrained, their willingness to pay for these is unknown. This can only be assessed through household level quantitative surveys, which are beyond the scope of this Impact Assessment. However, it may be that those suffering AIDS-related economic shocks would be willing to pay for services because of the importance of these services, sacrificing other items in their household budget.

The sale of land and houses is another important source of revenue for the municipality. HIV/AIDS will affect these sales in a number of ways, complicating the achievement of delivery targets and interfering with revenue flows. If land or property is purchased from the municipality with no financial ties between the buyer and the municipality existing after the sale these impacts will be minimal. The exception would be that house and land prices and the health of the market will be affected by HIV/AIDS via the epidemic's impacts on the local and regional economy. These are likely to result in reduced sales.

The municipality presently sells serviced erven to those who can afford market prices and to low income groups through development projects where the costs of prefinancing service provision is recouped. Sales through these projects are insured against the death of the land or house owner who, in addition, is required to name a beneficiary in the event of their death.

However, administrative costs will increase as the number of AIDS deaths rise, as changes in the financial and legal arrangements will have to be processed or repossessions conducted.

Even in cases where outstanding debt is covered by an insurance policy, death will decrease the profitability of sales. This is because property sales generate revenue in two ways, firstly through the capital payment and secondly through the interest received. Insurance protects the capital, but early payment following a death means the loss of interest income for the remaining years of the loan.

A related and important issue is the impact of HIV/AIDS on revenue growth. All major sources of revenue are related to the size of the town, in terms of area and population. By 2010 the population of the town will be smaller than it would have been in the absence of AIDS, and by 2021 it will be over 36% lower. This reduction in the size of the population has implications for planning of service delivery over the next ten to twenty years. This is particularly important in towns, such as Ongwediva, where infrastructure investments (such as water pumping substations, roads, etc.) are a significant cost item.

Equally, the demand for burial space and cost associated with its allocation, preparation and maintenance will increase as the death rate climbs and will need to be planned for. How great such an increase will be is difficult to estimate as some may leave Ongwediva to die, and others may return to Ongwediva to die.

In addition, the epidemic demands that the Council take the lead in preventing further HIV infections not only among its staff, but also in the community it serves. These new services will require not only additional staff, but also new programmes and materials whose introduction obviously has cost implications. However, the costs of inaction is likely to be greater.

Chapter 1: Introduction and Background

Introduction

The HIV epidemic is affecting every aspect of Namibian society. These impacts include, among others, a reduction in the population growth rate, alterations to the demographic structure of the population, economic losses through a reduction in Gross Domestic Product (GDP), as well as broader societal change as the nation comes to terms with its losses, and the need to care for the infected and the affected. Paralleling these national impacts are severe impacts on households and extended families. Food security is being undermined, breadwinners are dying, and household coping strategies are under unprecedented strain.

To respond to this national challenge, Namibia created the National AIDS Control Programme in 1990, which was eventually relaunched as the National AIDS Co-ordination Programme (NACOP) in 1999, underlining the need for a multi-sectoral response to the epidemic. Namibia is currently implementing the second HIV/AIDS plan (1999-2004), which outlines the responsibilities of the various sectors. Coinciding with the launching of NACOP in 1999, a National AIDS Committee was also formed. It is chaired by the Minister of Health and Social Services, and co-chaired by the Minister of Regional and Local Government and Housing. The co-chairpersonship by the Minister of Regional and Local Government and Housing is in recognition of Government's commitment to decentralisation, but is also in recognition of the fact that regional and local authorities are the ones who are closest to the people they are meant to serve.

While the need to respond to the epidemic places considerable burdens on regional and local authorities in terms of implementing effective responses to the epidemic, their ability to do so is undermined because it is taking place within the context of direct impacts *on the local authorities as well*. The local authorities will lose personnel to the epidemic, due to illness, death, or responding to the illness and deaths of family members. Further, HIV/AIDS will

increase the costs of doing business, and will effectively undermine the efficiency of the sector and reduce turnover, with negative impacts on employment potential and creation of tax revenues. Local authorities are therefore playing a central role in preventing and coping with the epidemic, while they themselves are directly affected in a variety of ways.

This volume deals specifically with the results of the assessment as they pertain to the municipality of Ongwediva. Data from the Ministry of Health and Social Services (MOHSS) surveillance survey conducted in 2000 indicates that antenatal HIV/AIDS prevalence rates for those aged 15-49 in neighbouring Oshakati was 38%. In effect, over one-third of the working age adult population of the municipality may be HIV positive, and will eventually die of AIDS, resulting in productivity, skill and economic losses. These high levels of infection highlight the need to better understand the implications for the city and its council.

Background to the Study

In 2000 the Chief Executive Officer of the Municipality of Windhoek initiated a process to consider the impacts of the HIV/AIDS epidemic on the municipality of that city, as well as the people it served. After discussions with counterparts in Walvis Bay and Swakopmund, the proposed investigation was broadened to include the two coastal towns as well, and was later further expanded to the two northern towns of Oshakati and Ongwediva.

Financing was sought for the impact assessments from the United States Agency for International Development (USAID), and provided via Family Health International, an international non-governmental organisation working in the HIV/AIDS arena. Technical support for the impact assessment was provided by Social Impact and Policy Analysis Corporation (SIAPAC) and was implemented by SIAPAC in conjunction with the Health Economics and HIV/AIDS Research Division (HEARD) of the University of Natal, Durban, South Africa and JTK Associates, a development consulting company located in Mbabane, Swaziland.

Aims and Objectives

The **aim** of the assessment was to provide detailed insights into the internal and external impacts of the HIV/AIDS epidemic on the five municipalities of Ongwediva, Oshakati, Swakopmund, Walvis Bay and Windhoek, as follows:

Internal Impacts

- the impact of HIV/AIDS on the personnel within the Municipality;
- on the ability of the municipality to meet its mandated responsibilities;

External Impacts

- on the businesses within the city;
- on the health services;
- on the economic and social well-being of residents living within the Municipality;
- on the overall quality of urban life in the city.

Of equal importance, the assessment was intended to 'mainstream' HIV/AIDS into the functions of the municipalities. This was to be accomplished through the development of an HIV/AIDS strategy and action plan following review of this report by the respective local authorities.

Specific **objectives** of the assessment are as follows:

1. Project the demographic impact of HIV/AIDS illness and death on the population of local authority personnel, and indicate needed additional human resources.
2. Project the demographic impact of HIV/AIDS illness and death on the population living in the local authority areas.
3. Project the economic impacts of HIV/AIDS on households in the local authorities' areas and consider the impact this will have on affordability and payment for local authority services and the overall revenue base.
4. Project the economic impacts of HIV/AIDS on businesses in the local authorities' areas and consider the impact this will have on the viability of key business sectors.

5. Qualitatively assess the impact on 'quality of life' for the local authority areas (e.g., ability of households to meet basic livelihood needs, levels of crime, street children, etc.).
6. Consider the costs associated with HIV/AIDS prevention activities for local authority personnel. Compare this to the costs associated with *not* implementing the intervention. Outline possible programmatic interventions.
7. Outline an HIV/AIDS strategy and action plan.

Methodology

The study was divided into four phases: design; implementation; analysis and write-up; and planning/integration.

Design

Mobilisation

Start-up was delayed for several months due to various technical requirements, and work on the Assessment only began in September 2001 when all outstanding agreements were in place. Work began with a series of inception visits by the Deputy Team Leader, Mr. Mouton of SIAPAC, to all participating local authorities. The purpose of these visits was to brief local authority executives on the assessment and begin preparations for the Inception Workshop.

Inception

The Inception Workshop was held at the Safari Hotel in Windhoek on 7 and 8 November 2001. It was attended by participants from each of the participating local authorities, among them Chief Executive Officers and finance and human resource managers. The purposes of the workshop were to:

- introduce participants to the aims and objectives of the project assessing the impact of HIV/AIDS on five Namibian cities (Walvis Bay, Windhoek, Swakopmund, Oshakati and Ongwediva);

- to seek agreement on project aims and objectives with participants, following review and discussion; and
- to plan and agree to a schedule of work with representatives of each local authorities.

These objectives were met. In addition, participants recommended that an Advisory Group be appointed to guide the work of the consultants and local authorities during the Assessment, and suggested the membership of the Advisory Group. Participants also agreed on the nature and type of information and data needed for the Assessment that were to be supplied by the municipalities, and established a schedule for its provision. The Workshop minutes are included in Volume 7 of this report.

Following this workshop an Inception Report was submitted. This contained changes to the propose schedule of work because of the late start of the Assessment, and the difficulties imposed by the pending Christmas break when few officers would be available to collect the requisite information.

Concurrent with data gathering activities was the completion of a detailed literature review. A bibliography is attached to this volume.

Following the literature review, and in addition to long-term dialogue and information gathering activities, qualitative data gathering instruments were developed to conduct interviews with municipal employees. Specifically, *qualitative* discussions were held with small groups of municipal officers. The aim was to gain insights into attitudes about HIV/AIDS and recommendations on how HIV/AIDS prevention activities should proceed within the local authorities. Two qualitative approaches were employed: 1) focus group discussions; and 2) story with a gap. These were supplemented with key informant interviews with municipal managers.

At the end of this Design Phase progress meeting were held (one in Windhoek, one in Walvis Bay, one in Swakopmund, one in Oshakati and one in Ongwediva), at which time Progress Report 1 was submitted.

Implementation

Implementation consisted of three activities:

- 1) reviewing then information made available and analysing the gaps in the data;
- 2) projecting HIV/AIDS impacts; and
- 3) implementing key informant interviews, focus group discussions, and story with a gap group discussion instruments.

As soon as the relevant data became available from the local authorities on municipal personnel, these were applied to projections of municipal personnel numbers. The 1998 projections of the demographic impact of HIV/AIDS were updated by MOHSS to include 2000 seroprevalence data (using the SPECTRUM group of models), and these were used as the basis for projecting the impact of the epidemic on the five local authorities and the populations they serve.

The model required a great deal of demographic data in order to complete the projections. Data from the Central Bureau of Statistics (CBS) and the Ministry of Health and Social Services (MOHSS) were used, and the assumptions made were, to the extent possible, the same as those used in the national projections on the demographic impact of HIV/AIDS. A more detailed discussion in this regard is included in Volume 7.

The data on local authority personnel and local populations were needed in a format that was both consistent and useable. These requirements were communicated to the local authorities, and during the initial start-up meetings the consultants provided the local authorities with a format for these data and agreed to a schedule for their provision. Most of the municipalities were able to comply but, despite everyone's best efforts, a number of delays were experienced in receiving these data.

Once the data became available, projections from the model were applied to the relevant local authority populations. For example, the model allowed the projection of HIV prevalence levels and AIDS-related deaths among municipal staff by cadre. Similarly, it allowed the

investigation of the demographic impact of the epidemic among the populations these authorities served, and allowed consideration of some assumptions about these effects on demands for services and abilities to pay for these.

To supplement the quantitative data and collect information on attitudes important for an understanding of the potential impact of HIV/AIDS on the five municipalities and the people they served, two qualitative approaches were used: 1) Focus Group Discussions (FGD); and 2) Story With A Gap (SWAG). FGDs are particularly useful in collecting detailed insights into sensitive issues such as HIV/AIDS. SWAG is a variation on the FGD approach, and is a useful tool in getting participants to consider their current situation in relation to a desired state, and discussing roadblocks and needed actions to move from their current state to a desired one. For this consultancy, the two approaches were used so that respondents could consider how the local authorities might best respond to the epidemic.

At the end of the Implementation Phase further progress meetings were held (meetings were held in each of the five municipalities), at which time Progress Report 2 was submitted.

Analysis and Write-Up

As data become available the impacts of HIV/AIDS on the local authorities were modelled. This took some time, given the complexity of the projections, particularly in relation to internal migration within Namibia, and given continued data gaps. The model does not easily accommodate internal migration effects, and assistance was sought from the developer of the model in this regard. In response to requests from the Consultant, Mr. John Stover of The Futures Group kindly developed the bridging formulae needed to allow the model to incorporate internal migration.

Qualitative/participatory findings were compiled using NUD*IST, a data analysis software package designed to systematically interrogate qualitative findings, and thereafter the key findings were incorporated into the reports.

The report was then submitted for review by the municipalities and comments solicited. A final series of progress meetings was held with each of the five municipalities in order to present the findings from the draft report and facilitate receipt of comments and feedback.

Planning and Integration

Methodologies to integrate HIV/AIDS into the activities of the three local authorities, and to assist the five municipalities in prepare concise HIV/AIDS Prevention and Response Strategy and Action Plans, were developed at an advocacy workshop with the five local authorities. This was held in Walvis Bay from August 12 - 16, 2002. This planning workshop assisted the five local authorities to review and analyse the findings from the reports. Following this, participants began the process of planning for interventions intended to mitigate the impacts on the municipalities themselves, including prevention programmes intended to reduce infection rates among municipal personnel and the communities they serve.

Following the workshop the reports were finalised in draft form for final circulation, incorporating comments and changes from the local authorities. These now constitute the draft reports, and include the action plan and advocacy strategies developed at the closing workshop.

Data Limitations

Throughout the Assessment participating local authorities were extremely co-operative and helpful in making requested data available to the consulting team. However, in several instances the data required to fully assess the impact of HIV and AIDS on a particular municipality was simply not available. Where this has occurred, the impact has been assessed qualitatively. For example, in Windhoek it has not been possible to obtain detailed data on the economic base of the city by sector (i.e., manufacturing, retail, tourism, etc.). Assumptions have had to be made about their relative importance, and this has made it difficult to more precisely determine the contribution made by these industries to the municipality's revenue base and the potential impact of HIV on this.

While the data gaps vary across the five municipalities, one purpose of the strategic and action planning workshop is to assist the municipalities begin to fill these gaps and each has now included data gathering and analysis in its draft action plan.

Structure of the Overall Report

This final report is presented in seven volumes. The first volume presents integrated findings across all five cities, including a more detailed discussion of the methodology used as well as background on Namibia, the HIV/AIDS epidemic and local government in the country, while the five subsequent volumes present specific findings for each of the participating local authorities. The volumes are as follows:

This report consists of seven volumes. This Volume presents findings for Ongwediva.

- Volume 1 Detailed study description, methodology, background information on Namibia, the epidemic in the country and on local government, as well as integrated findings arising from the Assessment of the Impact of HIV/AIDS on Five Namibia Cities
- Volume 2 Assessment of the Impact of HIV/AIDS on the Town of Ongwediva**
- Volume 3 Assessment of the Impact of HIV/AIDS on the Town of Oshakati
- Volume 4 Assessment of the Impact of HIV/AIDS on the Town of Swakopmund
- Volume 5 Assessment of the Impact of HIV/AIDS on the City of Walvis Bay
- Volume 6 Assessment of the Impact of HIV/AIDS on the City of Windhoek
- Volume 7: Appendices
 - Terms of Reference
 - Projections and Modelling
 - Field Instruments
 - Minutes of Advisory Committee Meetings
 - Inception Workshop
 - Prevention and Response Strategy and Action Planning Workshop
 - Bibliography

The intention is that each volume of this Assessment can be read as a stand-alone report. In order to present readable and comprehensive reports for each participating local authority, there is, however, some duplication between these volumes, in that a brief discussion of background information, the structure of the report, and an overview of the methodology used are included in volumes 2-6. However, a detailed discussion of methodology, particularly that related to the models used to present demographic projections of the impact of HIV/AIDS on each city, as well as the planning and strategy development matrices used, will be found in Volume 1 of this study.

Structure of this Volume

This volume presenting findings for the town of Ongwediva is structured as follows:

Chapter 1	Introduction, Structure of the Report, Methodology and Background to the Study
Chapter 2	The Town of Ongwediva
Chapter 3	The Impact of HIV/AIDS on the Town of Ongwediva, its Population and Economy
Chapter 4	The Impact of HIV on the Ongwediva Town Council
Chapter 5	The Way Forward

Chapter 2: The Town of Ongwediva

Introduction

Ongwediva is situated in northern Namibia, in Oshana Region, less than six kilometres from Oshakati. It was originally started as a residential and institutional settlement in the 1920s under the colonial government, mainly to accommodate South African administrative and military personnel. It became a town on the dissolution of the South African dispensation in 1990, with its Town Council operating under an agency agreement with the Ministry of Regional and Local Government and Housing (MRLGH) until 1998. In July of that year, Ongwediva became a fully autonomous town, operating independently with an elected Council.

This chapter presents information on Ongwediva, its people and Town Council.

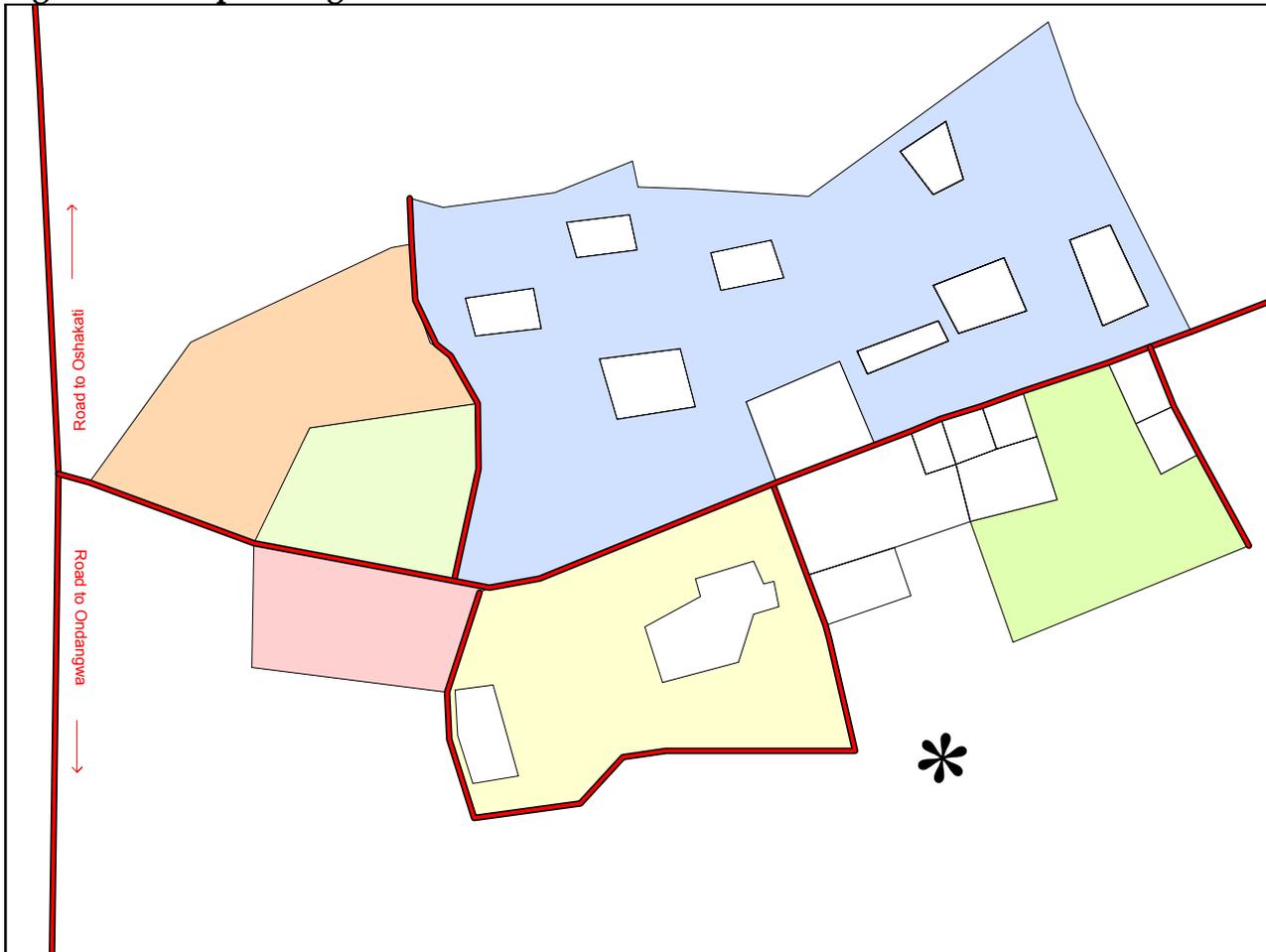
Demographic Profile

In 1991, the census found the town's population at 6,197. In 2000, Council documents estimated that the town was growing at a rate of 3.5% per annum. Unfortunately, it is not possible to compare 1991 census data with that from 2001 in order to confirm this rate, as demarcation changes in enumeration areas mean that the preliminary 2001 census findings now include the original Ongwediva town data within a far larger enumeration area.

It is estimated that town residents now number an estimated 9,000 individuals, plus another 21,000 outside of the townland borders that are not, strictly speaking, part of the municipal area and therefore are not part of municipal planning. It should be noted that the figure of 9,000 residents in Ongwediva town, used in this Assessment, was agreed with Town Council officials prior to preparing the demographic projections which model AIDS impacts on the town's population, as discussed in subsequent chapters of this report.

Ongwediva town is divided into formal and informal residential areas and, with the formal areas planned and having access to services. The Town Council estimates that most residents (5,500) live in the formal, serviced area, which some 3,500 residents live in informal areas.

Figure 2.1: Map of Ongwediva



Socio-Economic Status of Residents

Ongwediva is an educational centre of north central Namibia, and in 2001 had some 11,649 learners in 14 schools (including one private school) and colleges in the town. Included among these establishments are the only Teacher Training College, the only Vocational Training Centre as well as the only School for the Disabled in the north central part of the country. Many of these learners are drawn from the surrounding area and towns. One of the development challenges cited by key informants during interviews is creating sufficient employment opportunities for these young people.

While little socio-economic data are available for Ongwediva, formal employment and income levels are assumed to be higher than in Oshakati. Many residents are employed by the education sector and other institutions in Ongwediva itself, or work for government in neighbouring Oshakati or Ondangwa. According to the Town Council, this is because most residents of the town (approximately 80%) live in formal housing on serviced erven and are thus likely to be in full-time employment in order to maintain these residences. In addition, Ongwediva is viewed as one of the best residential area for many of those working in neighbouring Oshakati where formal housing availability is more limited. The Council estimates that 75% of its residents earn monthly incomes, and that 50% of these are civil servants.

Economy

The economy of the town is based on commerce, primarily the retail sector, with the informal sector playing an important role, including several small workshops in the town (garages, brickmaking, etc.). Housing construction is the most active sector of the economy, accounting for a large share of local employment, and contributes some 75% of the Council's annual income. The Town Council actively seeks to promote investment, particularly that related to service and professional activities, but struggles against the perception that Ongwediva is primarily a residential town. However, in recent years several larger industrial investments have opened in the town, including a large precision engineering workshop and a precast concrete manufacturer.

Commercial activities in the town are supported both by residents and those from surrounding areas. Many of the town's residents are formally employed, a number of these working for Government and other institutions in both Oshakati and Ongwediva, including the numerous educational institutions based in the town itself.

The economic base of surrounding areas, which help support the retail and service industries in the town, is very different to that of the town itself. The region has high levels of unemployment (39%) and relies heavily on subsistence agriculture. According to Labour Force Survey data, subsistence agriculture is the main source of income for almost 45% of this population. The 1998/99 Annual Agricultural Survey indicates that this consisted mainly of cereal crops, with some livestock production, mainly cattle and sheep. Production is very labour intensive, and labour shortages are common. According to the same survey only 30% of farmers owned at least one plough and only 11% held a ploughing ox. Migrancy in search of employment, from areas surrounding the town, to Central and Southern regions is common and many of the households in the region relied on cash remittances, 8.3% as the source of primary income and almost 13% as a secondary source.

The success of Ongwediva's economy is therefore reliant on the health and performance of the regional economy and, to a lesser extent, the regional economies in the centre and south of Namibia via migrant labour and cash remittances.

The Town Council

Ongwediva Town Council exists to provide quality services to the community, within available resources, and to promote the town's socio-economic development. It meets these objectives through the provision of water, electricity, sewage, refuse removal, roads, housing, planning and infrastructure development services to residents.

The Town Council has been providing these services as an autonomous and independent body since 1998. Since that time the Council has focused its efforts on building the institution's capacity to operate and provide these services to the community, with particular attention being focused on developing staff capacity and on strategic planning.

Ongwediva Town Council operating budget in 2000/1 was N\$17.3 million. Over 50% of its revenue is derived from the sale of serviced land which is in demand because of the level of services available in the town. Government development grants assist infrastructure delivery, such as roads and sewerage.

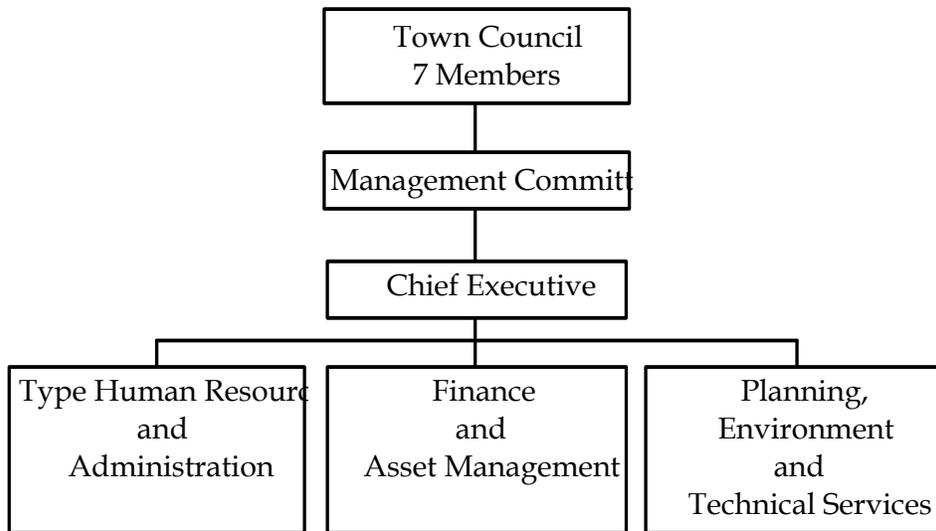
Table 2.1: Ongwediva Operating Budget 1998/9 - 2001/2

	1998/9	1999/2000	2000/01
Total Expenses	12,044,885	18,453,453	17,338,804
Total Revenue	8,277,761	9,608,175	12,823,295

In 2000/1, salaries and benefits totaled N\$4,031,370, or 23% of all expenses. Much of the town’s budget surplus is directed towards capital improvements, such expansion of the water and sewerage systems as well as the servicing of additional erven for sale to the public.

In order to provide these services and develop the town some 59 staff were employed (November, 2001). These employees report, through the Town Clerk who acts as the Chief Executive Officer, to the seven-person elected Town Council. The following figure illustrates the Council’s organisational structure.

Figure 2.2: Ongwediva Organisation Chart



Key Functions

During key informant interviews, senior Council managers identified the following as key functions:

Table 2.2: Key Departmental Functions, Ongwediva Town Council

Department	Key Functions
Chief Executive Officer	Co-ordinates the work of all council departments, promotes investment and improves productivity through training, development and adequate compensation of staff.
Environment, Planning and Technical Services	Ensures sound infrastructure development of the town, through planning, implementation and maintenance of existing and future projects. Provides economic layout for developments. Manages and controls Town Engineers Department which includes planning and building control, water supply and distribution, sewerage treatment and irrigation plant, building maintenance, roads and storm water drainage, electricity transmission and distribution and the workshop.
Finance and Asset Management	Secures financial resources. Ensures efficient and economic utilisation of resources for the economic development of Ongwediva. Ensures all Council financial obligations are met, ensures all revenues are collected, ensures control account reconciliation, and critical accounting tasks are undertaken each month, manages debtor levels through improved collection.

Core and Peripheral Municipal Functions

When analysing these functions, while stressing that all were important, senior Town Council managers indicated during interviews that the following can be considered as core and peripheral functions:

Table 2.3: Core and Peripheral Council Functions, Ongwediva Town Council

Core	Peripheral
Water	Land
Refuse Removal	Roads
Sewerage	Civic Housing

Services

Although the town consists of both formal and informal areas, Ongwediva is the only town in northern Namibia that is fully properly planned, surveyed and laid out. There are some 2,939 serviced plots (erven) and the Council estimates that some 4000 individuals reside in the informal areas. Both informal and formal areas are connected by all weather gravel roads and are fully serviced. Service level options, however, differ between the formal and informal areas. Communal waterpoints and sanitation are available in the informal areas for

those unable to afford individual water connections, but do require payment. As of 2001 the following services were provided to households:

Table 2.4: Service Provision, Ongwediva Town Council

Service	# Connections
Individual water connection (Formal Area)	2670
Sewerage Connection (Formal Area)	2500
Electricity Connection (Formal and Informal Areas)	not available
Communal Waterpoints (Informal Area)	238

Refuse collection in Ongwediva is privatised and, although electricity provision was outsourced on a 50:50 basis, this service is now provided by NORED, a private company in which the Council will acquire shares. Any profits accruing to the Town Council from the sale of electricity will be derived from dividends paid on these shares. Four towns will own the shares of NORED and their distribution between each of these authorities is still to be agreed.

Council's main functions are therefore water distribution and maintenance of the urban reticulation system, planning (i.e., the division and sale of plots), road maintenance and ensuring that outsourced services are adequately provided.

Chapter 3: The Impact of HIV/AIDS on Ongwediva

Introduction

This chapter describes the situation regarding HIV/AIDS in Ongwediva, its likely impacts on the demography of the city, its economy and community, as well as the local response to the epidemic.

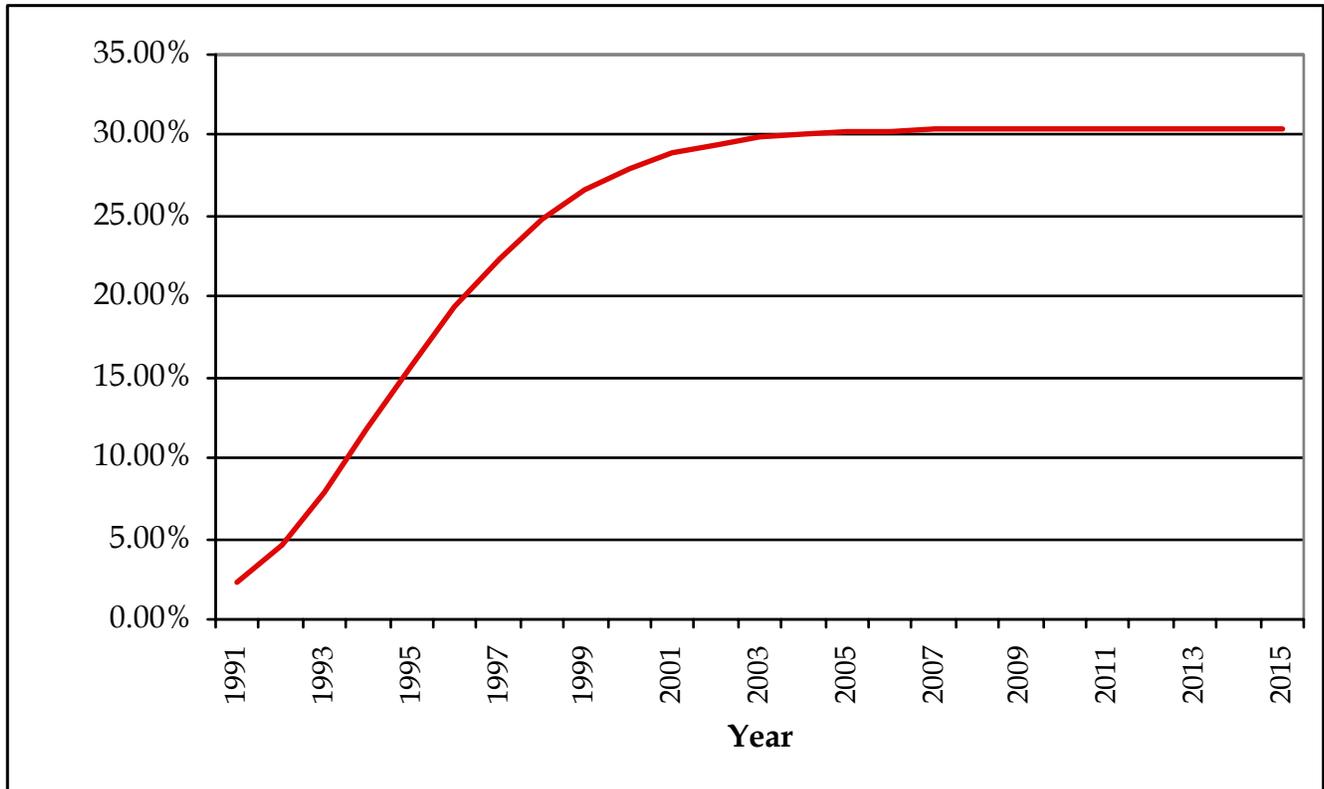
HIV Prevalence

Namibia undertakes antenatal sero-surveillance surveys to establish the adult HIV prevalence rate every two years. The last such survey completed was in 2000. Unfortunately, Ongwediva is neither included nor reported on as a separate site in these surveys. Therefore, the antenatal prevalence rate for the town is assumed to be 28%, the same as that in neighbouring Oshakati town less than 6 kilometres distant, for which there is data. This adult prevalence rate is some 6% higher than the national rate of 22.3%, and, together with Walvis Bay, Ongwediva and Oshakati have the third highest prevalence of all the sites surveyed by the MOHSS in Namibia, after Katima Mulilo (in Caprivi Region) and Windhoek.

This high rate implies that over one-quarter of the population aged 15-49 in Ongwediva are likely to be infected. Unfortunately, Namibia's sero-surveillance data do not provide a breakdown on prevalence by socio-economic or educational status, and it thus becomes difficult to assess who is infected and affected by the disease within any location.

HIV prevalence in Ongwediva appears to be very close to its peak. If the epidemic continues to follow past trends, HIV prevalence will peak at 30% by 2003/4. We do not, however, know what will happen after the peak, as nowhere in the world has the epidemic yet run its course. For the purposes of this study it has been assumed that HIV will remain stable after this peak, but this may very well be an optimistic assumption.

Figure 3.1: Projected HIV Prevalence, Ongwediva (1991 - 2015)



The causes of this higher HIV/AIDS prevalence rate in Ongwediva are high levels mobility among the population in Oshana Region in particular, and in northern Namibia generally. Firstly, Oshakati and Ongwediva are locations of first migration for individuals from the northern regions of Namibia seeking employment and an urban economic base. Secondly, the region appears to experience higher than average economic migration from neighbouring Angola. Finally, there appears to be a great deal of movement of people between Ondangwa and Oshakati (Ongwediva is in between the two) and other areas of Namibia, such as Windhoek and Walvis Bay.

However, while HIV/AIDS affects everyone, *regardless* of their economic well-being and status in society, the disease is known co-vary with poverty and educational status. Poverty is associated with HIV for a number of reasons primarily related to access to information and medical care. Better-educated individuals have more access to information as to the risks of unprotected sex and frequent partner change and are therefore more likely to change their behaviour. Infection with a sexually transmitted infection (STI) increases an individual's risk

of being infected with HIV. Poor people tend to have higher rates of STIs because they have lesser access to quality medical care. In addition to these factors, poor people, and particularly women, may be placed at risk of HIV infection because of behaviours motivated by poverty, such as commercial or transactional sex work, and dependence on males for economic welfare. The relationship between HIV and poverty is, however, not a simple one. Many wealthier individuals are also infected. Higher income leads to greater access to resources that can lead to more sexual partners and eventual HIV infection. Infection may therefore occur across income groups, but the ability to cope with infection is more problematic for the poor.

The Demographic Impact of HIV/AIDS on Ongwediva

This section of this report discusses the demographic impacts of these high rates of infection on the population of Ongwediva over the next several years. As mentioned previously, we do not know a great deal about what will happen to HIV prevalence after it peaks. Therefore, while we have a high level of confidence in the number of deaths over the next 10 years (as these will result from infections that have already occurred), estimates further into the future must be treated with extreme caution.

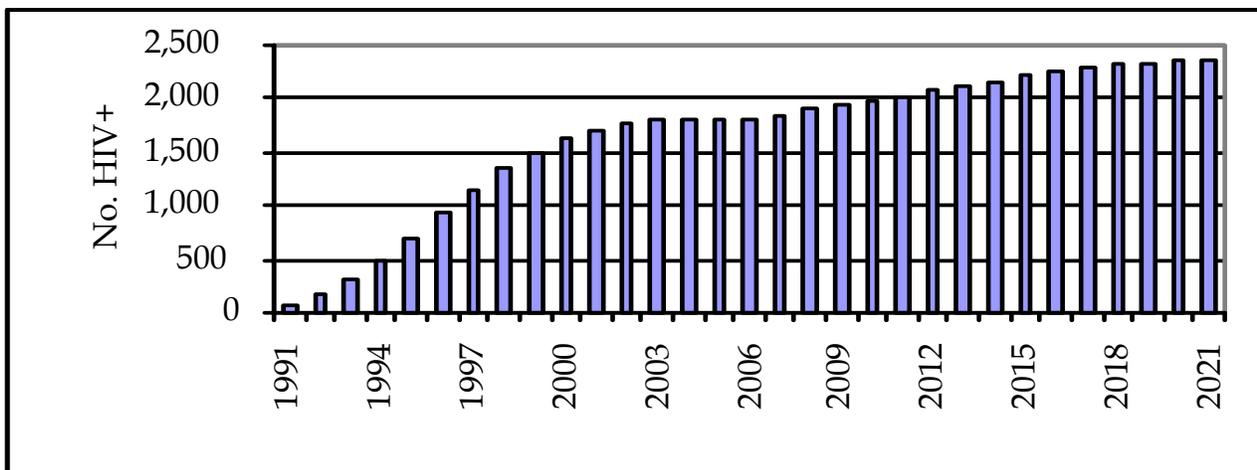
The data presented below project the AIDS mortality (or death rate) for Ongwediva. They are based on projections derived from models of the demographic impact of HIV/AIDS on the general population. The SPECTRUM group of models was used for this purpose, and the assumptions and methodology upon which the projections are based are discussed in more detail in Volume 7. It is, however, important to note that these assumptions were discussed and agreed at progress meetings held with Ongwediva Town Council officials and with the Working Group prior to their incorporation in the model.

This section of the report discusses the impact of the town's presently high HIV prevalence rate on its population and future growth.

Number of People Infected with HIV

While HIV prevalence is a useful and important measure of the level of HIV in a community, it is sometimes more meaningful to convert prevalence into the number of people infected. The following figure displays the number of people infected with HIV, based on the present prevalence rate in the town. As can be seen from the figure, some 1,500 people are presently estimated to be HIV-positive in Ongwediva, rising to 2,000 individuals by 2012 and close to 2,400 in 2021.

Figure 3.2: Number of People HIV+, Ongwediva (1991 - 2021)



The figure illustrates the flow of HIV infection, with the number of people infected in the early stages of the epidemic increasing rapidly. This is because, at this stage of the epidemic, most of those who are HIV positive are newly infected and the mortality (or death) rate is low. There are, therefore, many new infections and few deaths among the population. Over time, the rate at which people are infected slows. The reason for this decline in the rate of new HIV infections is because a greater proportion of those vulnerable to the disease are already infected.

In practical terms, this means that at the beginning of the epidemic, when only one person in the town was infected, whomever they had sex with ran the risk of infection. In the later stages of the epidemic, an infected person may well have sex with another infected person,

and as there is then no chance of a new infection, this results in a slower rate of growth in the epidemic (although the asymptomatic phase of HIV is shortened for two HIV positive sexually active partners because viral loads are increased).

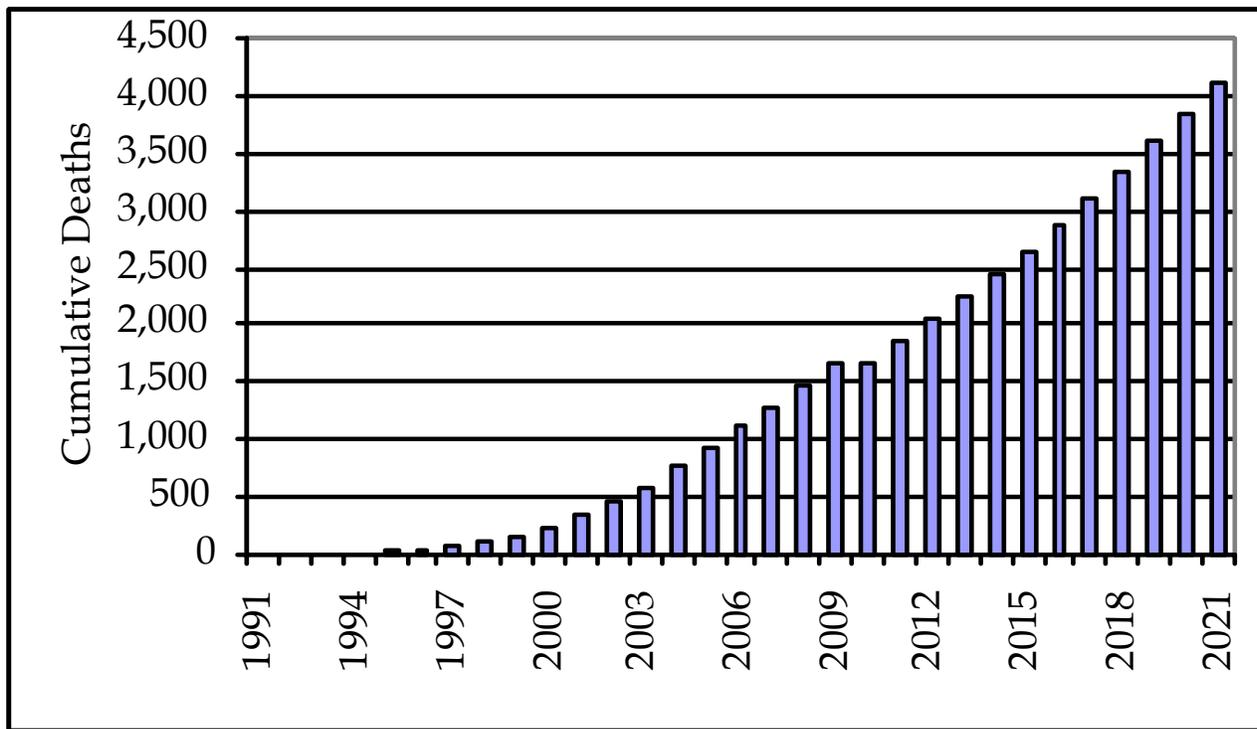
However, as the rate of new HIV infections declines the mortality rate increases as more of those who are HIV positive progress to AIDS and then die. At this stage of the epidemic these two factors combine and HIV prevalence stabilises. The number of HIV infected people, however, will continue to increase despite a constant prevalence rate because the town's population will grow. The prevalence rate thus remains constant although the number of infected people increases.

This is illustrated in Figure 3.2 above. The number of people infected grew rapidly from the beginning of the epidemic until 2001. The growth rate then slowed, when prevalence was projected to stabilise but the number of people infected will continue to increase as the population of the city grows.

AIDS Deaths

The HIV rate in Ongwediva means that mortality rates in the city will dramatically increase. While HIV prevalence is close to its peak, the lag between infection and death means that the AIDS epidemic is a number of years behind HIV infection. The AIDS death rate is likely to peak only eight years *after* HIV has peaked. Figure 3.3 displays number of people who have or are expected cumulatively to die of AIDS in the town.

Figure 3.3: Cumulative AIDS Deaths, Ongwediva (1991 - 2021)



The graph suggests that, given the level of infection to date, an estimated 450 people in Ongwediva have died as a result of AIDS by 2001. By 2010 the figure is likely to be closer to 1,700. The 1,250 deaths expected to occur between 2001 and 2010 are largely unavoidable (without access to anti-retroviral treatment), because these will result from existing HIV infections. Deaths from 2010 onward could be avoided *if* future HIV infections can be reduced. By 2021, cumulative AIDS deaths are expected to exceed 4,000, but it is important to stress that *many* of these can be avoided.

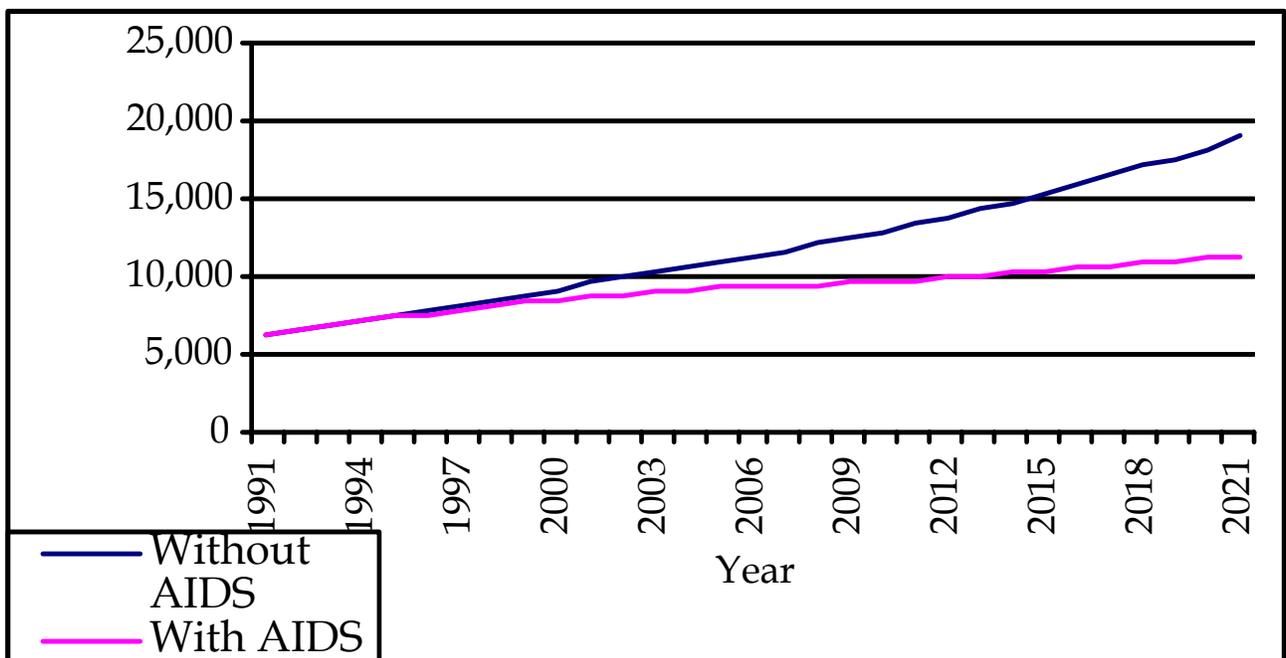
These AIDS-related deaths will affect the size of the population of Ongwediva in two ways. First, the deaths will directly affect the size of the town's population as individual residents die. Secondly, HIV/AIDS affects young adults. The death of young adults reduces the number of children born. This is because parents die before giving birth to all the children they would have had if they had remained uninfected. As a result of AIDS, therefore, the population of the town becomes, smaller as some of its residents die and others are never born.

Encouraging destigmatisation, wellness programmes and positive living for those infected may reduce AIDS deaths, and should this become more widely available in Namibia, through treatment (antiretroviral therapy-ART). Treatment options include the prevention of Mother to Child Transmission (MTCT) which is relatively inexpensive, and now being put in place in many countries in the Southern Africa region with high levels of infection (e.g., Botswana and Swaziland). ART for adults, which although less expensive than previously is unlikely to become widely available in the short to medium term due both to its cost and delivery problems as this therapy requires consistent monitoring by health professionals.

Population Growth

It is, however, expected that Ongwediva will continue to grow, albeit at a slower rate, as a result of the high level of inward migration from other areas. The following figure presents the projected population of the town both 'without AIDS' and what it is now likely to be in the face of these projected high rates of infection and expected deaths.

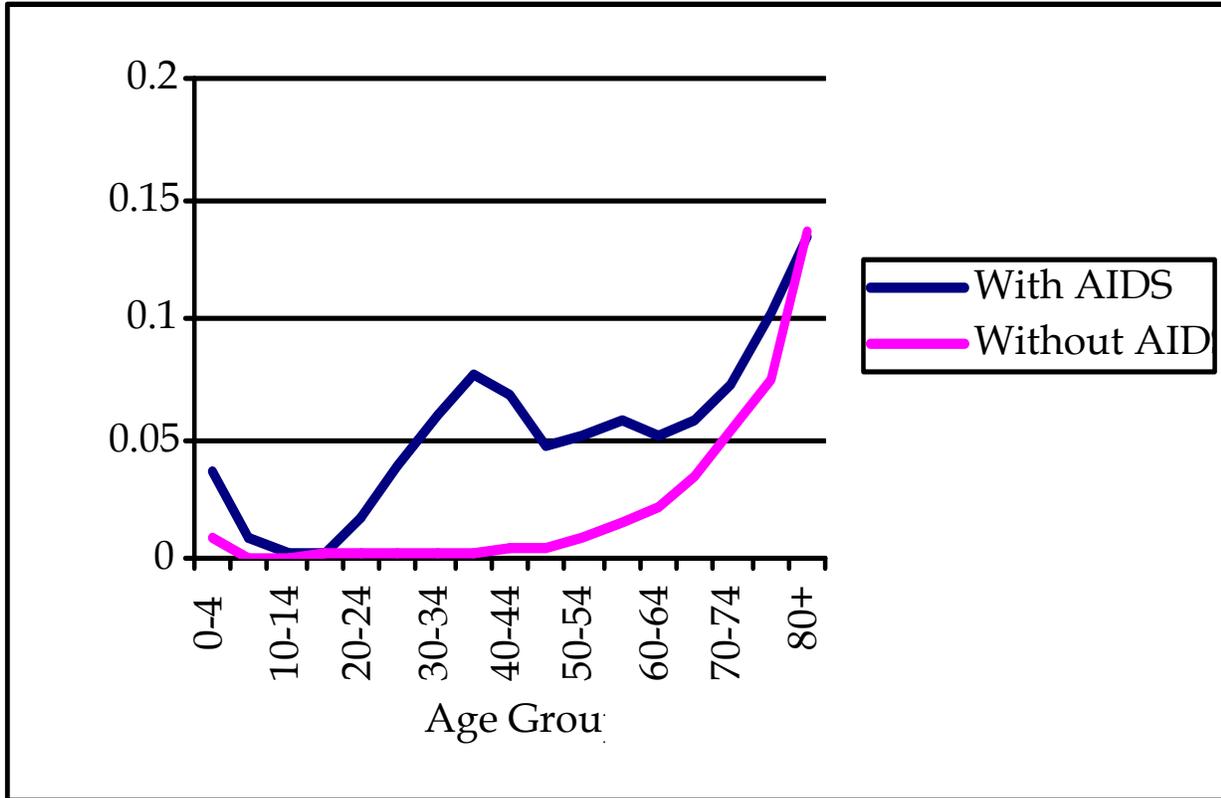
Figure 3.4: Population With and Without AIDS, Ongwediva (1991 - 2021)



Currently the population of the town is estimated to be slightly over 9,000 individuals. In the absence of AIDS the population would have been closer to 10,000. While the population of Ongwediva will continue to grow, Figure 3.4 shows how much larger its population would have been by 2021 in the absence of AIDS.

The socio-economic impacts of HIV/AIDS are severe. This is not only because of the number of deaths and the resultant reduction in the rate of population growth, but because those who are dying are in the productive (or working) age groups. Unlike epidemics of the past that targeted the weak, the very young and old, HIV infects the sexually active population, with infection rates highest in the 25-35 year old age group. It is therefore, not only the mortality rate that increases, but its distribution between age cohorts also changes. Figure 3.5 displays the mortality pattern of Ongwediva with and without AIDS.

Figure 3.5: Mortality Rates With and Without AIDS, Ongwediva



The 'Without AIDS' line demonstrates a typical mortality pattern in a population. Between 0 and 4 years of age mortality is relatively high as a result of childhood illnesses. Mortality then remains low for many years, as few people between the ages of 5 and 30 die, and subsequently increases with age.

The 'With AIDS' line shows how this pattern changes as a result of HIV. Infant and child mortality will be higher as children are infected at birth. Mortality rates between the ages 10 and 15 will be much the same as before as very few young children are infected with the disease. AIDS mortality then increases dramatically from the age of 20, peaking at between 35 and 40 years of age. What this means is that 40 year old individuals experience a mortality rate typically associated with people over 75 year olds.

It is this change in mortality patterns which results in the socio-economic impacts discussed below. The age groups with the greatest increases in mortality as a result of AIDS are those most responsible for economic production and social care. They are the workers of Ongwediva and the parents of children living in the city.

Economic Impact of HIV/AIDS on Ongwediva

The Oshana Region is vulnerable to the economic impacts of HIV. As Ongwediva's economy is linked to and supported by the region, it too is vulnerable. Efforts to attract investment will be affected, as many investors may be reluctant to establish enterprises in areas where HIV prevalence is high.

As stated previously many households in the region rely on subsistence agriculture, and the loss of labour at key times in such a labour intensive environment can be devastating and have major implications for the community. Unlike in the case of formal employment, if a household suffers a fall in agricultural production that production is lost to the entire community. However, if an individual loses their job they will loss income, but the job itself is likely to be filled by someone else and production continues, albeit with a short-term reduction in efficiency and increased costs.

The importance of cash remittances in the local economy creates further vulnerability. It has been widely argued that migrants are at high risk of infection. Their illness and loss of earnings affects themselves and the households they remit to. While migrants become ill and lose their jobs they may be replaced by others, income streams to the region are likely to be seriously disrupted. According to a NEPRU study remittances are more likely to come from established households. New migrants may, therefore take time to establish themselves before they can remit money home. Income is likely, therefore, to be reduced within the entire community.

When income is reduced, not only to the household, but to the region as well, there is a ripple effect. Households that lose income are no longer able to spend at previous level, this affects the income of shopowners and in turn producers in the region and has, therefore an amplified impact on the community. In Ongwediva this means that the household impacts in the surrounding areas will have a detrimental affect on the retail and service businesses in the town.

Households and individuals in the town itself will also be affected. Individual's face reduced productive capacity, often resulting in lowered income, as they become unable to work. At the same time as access to money becomes constrained, medical and other expenses increase.

The situation is the same at the household level, as individual illness often results in a reduction in household income or production. Further, the clustering of HIV infections can worsen the situation. This is because HIV is primarily a sexually transmitted disease, and households therefore tend to suffer from multiple infections. The impact on income and production is then further exacerbated as productive activities and labour resources are diverted towards the care of ill household members. Finally, the illness leads to death and the household is faced with the cost of a funeral (and often, later, a second funeral). In order to survive these impacts households may be forced to sell assets, borrow money or rely on support from extended family members and friends. While such strategies may dampen

impacts in the short term, they tend to lead to long term difficulties. Many households in Ongwediva are poor and will have limited ability to deal with the impacts of HIV. The social consequences of such an inability to cope may be far more profound than the economic impacts.

Affected households typically change the level and composition of the goods and services they demand. Expenditures are shifted toward medical services and away from savings and other forms of consumption. Retailers and producers will, therefore, be affected in different ways, some will experience an increase in demand and others a decrease. The economic impacts of HIV will, therefore, be felt not only by those infected, but also by the entire community.

The Social Impact of HIV/AIDS on the Community

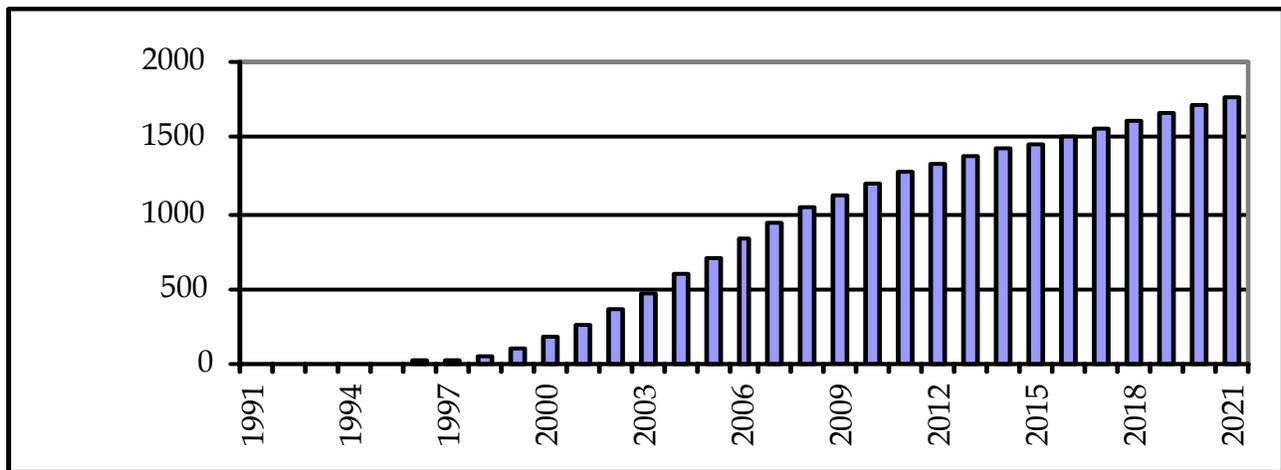
HIV/AIDS profoundly affects families and communities, resulting in the loss of labour and assets, as well as socio-cultural skills, and places almost unprecedented stress on community and extended family networks.

"Some of the most striking images of the HIV epidemic are of families, but of unfamiliar families: a grandparent surrounded by grandchildren, child-headed families, often brothers and sisters and cousins bonded together, dying adults tended by their children and communities of children without parents."
Peter Piot, Executive Director, UNAIDS

Orphans

The nature of HIV/AIDS is that it impacts communities and households over many years, and as the rate of illness and death increases, so the structure of these families and communities alters. As noted previously, the age groups most affected by the increase in mortality are the worker and the parents. Losses in these age groups will leave many children in the city without parents. The following figure displays the rise in the number of children orphaned as a result of AIDS in Ongwediva.

Figure 3.6: Orphans as a Result of AIDS, Ongwediva (1991 - 2021)



It is estimated that there are already over 250 children in Ongwediva who are currently under the age of fifteen and have lost one or both parents as a result of AIDS. This number is expected to increase to almost 1,300 in the next 10 years. The ability of community to absorb and care for children who have lost their parents will be strained by this rapid increase in orphans.

The impact of HIV/AIDS on children is arguably the single biggest long-term development impact. Failure to provide appropriate and adequate care for children who have lost their parents has serious implications for their development and their long-term growth towards becoming productive, responsible members of any society.

The impacts of HIV/AIDS will change the demand for and type of urban services needed. Service providers, primarily governments and municipalities, will be expected to provide increased health and social welfare services, home-based and community care, and meet changing housing and education needs.

“In the past children were not allowed to attend funerals, now it is becoming a normal feature, as they are the ones affected when one or both parents are not living anymore.” SWAG Participant, Ongwediva.

At the same time as there is an increase in demand for services the ability to provide these is eroded as key staff are lost. Nurses, teachers and social workers are not immune from infection and their mortality rates will also increase. The impacts of HIV/AIDS on services will have an impact on the entire community infected or not, orphaned or not.

Chapter 4: The Impact of HIV/AIDS on the Town Council

Introduction

This chapter reports on the impact of HIV/AIDS on the Town Council of Ongwediva. First, the ways in which HIV/AIDS affects local authorities are outlined. This is followed by a discussion on the internal impacts on the Council itself, these are then subsequently costed.

The next section of the chapter examines the external impacts of the epidemic in more detail, those affecting the Ongwediva community, the quality of life in the town, its economy and how these then affect the Council itself.

Impacts of HIV/AIDS on the Town Council of Ongwediva

HIV/AIDS results in demographic, social and economic changes in society that will continue to affect both the public and private sectors in Namibia for the foreseeable future. The Town Council of Ongwediva will not be exempt from these impacts.

At the outset, what needs to be understood is that HIV infection precedes illness and AIDS death by some six to eight years, and for much of this time the disease remains invisible in those who are infected. It is only over the last few years of the individual's life as HIV progresses towards AIDS that the frequent bouts of increasingly more severe illness are experienced. In other words, the AIDS mortality presently being experienced within Ongwediva Town Council Municipality results from HIV-infections acquired some six to eight years ago. The full impact of AIDS on the Municipality is only likely to be felt between 2008 and 2010 when the numbers of those falling ill and dying will reflect the currently high prevalence rate. This is what makes the immediate implementation of planning for the impact of AIDS illness and death within the municipality so important in order to prevent future infections, mitigate the impacts of the disease on the functioning of the Municipality and reduce the costs of the epidemic.

The challenge is that the epidemic erodes the ability of institutions, including local authorities, to provide services, as it reduces *both* operational efficiency and municipal revenues, while the personnel losses induced by HIV/AIDS affect the quality of services provided. These impacts result from the sickness and death of municipal personnel infected with HIV, and can include:

"The educated, skilled and experienced employees are those dying of this disease." FGD Participant, Ongwediva.

- loss of productivity;
- increased absenteeism;
- cost of sick and compassionate leave;
- increased cost of benefits; and
- increased recruitment and training costs to replace lost staff members.

Studies in West Africa have demonstrated that HIV-positive individuals generally lose some four to six months of work time prior to the onset of AIDS, following which s/he is often absent from work, until death (Carr-Hill, Kataro and Katahoire, 2000). The reality in Southern Africa appears to be increasingly frequent bouts of illness and thus the loss of productive work time until death. There is thus a system-wide loss of experience and professionalism as the replacement and managerial stock, if available, becomes increasingly under-trained and under-experienced over time.

Other losses are less easily quantified, such as those relating to the loss of experience (including institutional memory) and the effect of the illness and death of colleagues on staff morale.

Further, more managers and other skilled personnel will need to be trained within a given period of time than would otherwise have been the case. This results in increased expenditure on training (and recruitment) without an expansion in the supply of personnel overall, with less funding available for quality and service improvements.

"People already do not want to work in Oshakati or Ongwediva, as they are rural, so it would be more difficult to replace qualified people. People who die of AIDS would leave a big gap which will be difficult to fill." FGD Participant, Ongwediva.

Similarly, recruitment costs increase. However, the largest costs to any system remain those from increased benefit payments and absenteeism due to illness, caring for sick family members and funeral attendance.

Simultaneously, AIDS affects the national economy (through the loss of skilled labour, reduced productivity, as well as declining savings and investment, etc). In countries where prevalence rates are 20% or higher, such as Namibia, the GDP growth rate is expected to decline by some 1.5% to 2.6% per annum solely as a result of the disease. By 2020, GDP would thus be some 30% to 56% lower than it would have been (Bonnell, 2000). While no detailed studies have been done on the macro economic impacts of HIV and AIDS in Namibia, the Government of Botswana has commissioned such a study. It concluded: "AIDS is a development of such proportions that it will inevitably have an impact on government revenues and spending, and therefore on the budget balance and government saving or borrowing. AIDS will have direct effects on some key areas of government spending, most obviously the health budget, but there will also be a range of indirect effects as the ability to raise tax revenues is affected." (BIDPA, 2000).

Thus at the macro level, the epidemic will reduce Government's ability to commit funds to local government, in the form of subsidies, grants and development loans, as AIDS-related demands from all sectors on available resources increase while revenues themselves decrease.

These impacts are particularly pertinent in the case of Ongwediva, as the Council is young, and in the process of building itself. AIDS will make this process more complex and more difficult, and the impacts of the epidemic will require even more careful monitoring and thoughtful mitigation in order for the Council to maintain its institution building focus. The remainder of this chapter discusses these impacts on Ongwediva Town Council.

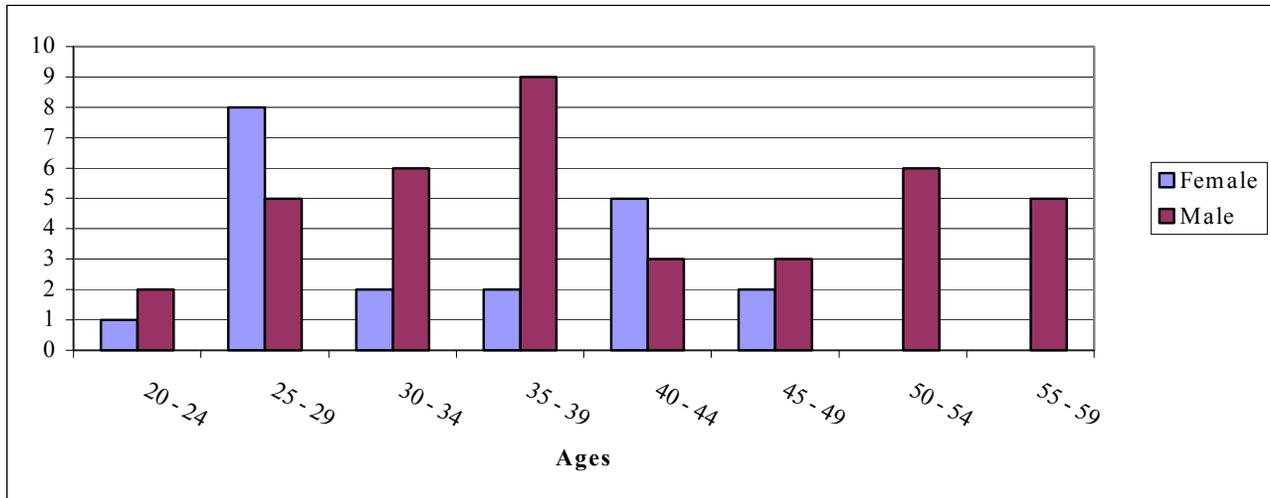
Internal Impacts

Demographic Impacts on the Town Council of Ongwediva

In 2001, Ongwediva Town Council employed 59 individuals. While the majority of these employees were males, the gender balance in the Council is more equitable than in the other

authorities participating in this Assessment, with 33% of all staff being women. The following figure illustrates the age and gender breakdown of Council staff. Of concern, is that many of the staff are in the age ranges most likely to become infected with HIV - 20 to 30 years of age for females, and 30 to 40 for males.

Figure 4.1: Personnel by Age and Gender, Ongwediva Town Council (2001)

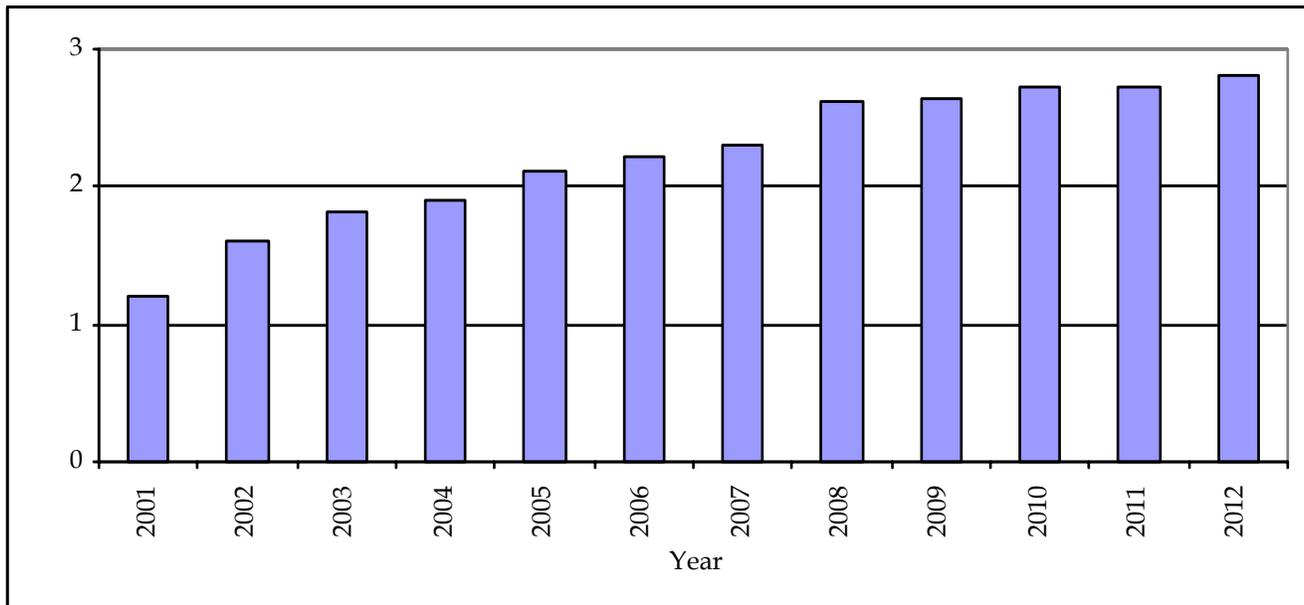


The demographic impacts of the HIV/AIDS epidemic were then projected on this sub-population, using the SPECTRUM data developed for the overall population of Ongwediva. The period 2001 - 2012 was chosen for these projections, because these reflect the deaths that are likely to result from the current HIV prevalence rate in the town. It is assumed that the Council will act to strengthen its efforts to prevent and reduce future infections and thus reduce the death rate among its staff beyond 2012.

The assumption in these projections is that staff lost to the epidemic will be replaced, but that the total staff complement will remain the same size, as the economic impact of the epidemic will reduce the need to increase the numbers employed by Council.

Over the period 2001 - 2012, Ongwediva is projected to lose some 26 staff across all staff grades to AIDS, provided that total staff numbers remain the same. The AIDS mortality rate for the Municipality is illustrated in the following figure:

Figure 4.2: Total AIDS Mortality, Ongwediva Town Council (2001 - 2012)



As the figure shows, AIDS deaths among Council staff are projected to continue to rise from between 1 and 3 deaths annually, peaking in 2009 at this latter figure and staying at this level until 2012.

The Town Council uses the Patterson system, with its current staff occupying grades A to D. Close to half of all staff are in the lowest (band A) of this system. The latter is the lowest grade, occupied primarily by unskilled labourers, and the three lowest grades. The AIDS death rate will be highest among these bands, simply because there are more people in these bands.

These levels of AIDS mortality will impact on the Council through increased absenteeism (from sick and compassionate leave as well as the need to care of sick and dying relatives), productivity losses and increased replacement and training costs. These impacts will require management and mitigation, with particular attention being paid to the financial and human resource implications, discussed below.

Human Resources Management Information System

The initial, and critical, step in managing the impacts of the epidemic on the Town Council is to make available data on personnel leave and absence from duty, by type (i.e., whether sick leave, compassionate leave for funeral attendance, etc., age and gender profile, etc.). This permits managers to analyse trends and costs and indicates where the loss of critical personnel may occur, allowing time for preliminary and succession planning, etc.

Ongwediva maintains human resource records and data, and was able to provide the consulting team with computerised personnel data as requested. However, refinement is needed to improve the type of data that should be provided to managers on a monthly basis. Specifically, it is recommended that leave data be collated monthly, by type and length of leave taken (i.e., whether sick, vacation, compassionate, or bonus leave, etc.). The costs of this leave (by type) also needed to be calculated monthly. These data will allow managers to audit leave trends and track where problems may be developing in terms of staff absence.

Sick Leave

The amount of sick leave taken by staff because of AIDS -related illness is one of the main costs of the epidemic to any employer. The reality of HIV/AIDS is

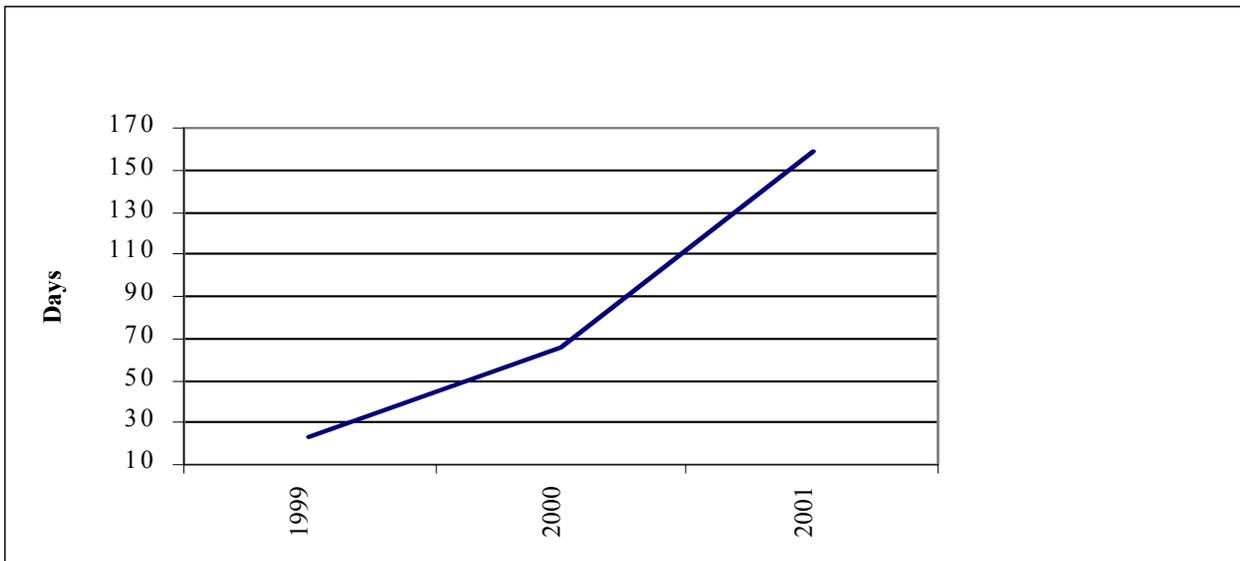
“Sick leave policy should be changed, because it currently states that a person cannot be replaced until they have died or reached a given leave period. Most of the time sick people cannot perform their jobs, but they still come to work because they are afraid that they may lose their income.” KII, Ongwediva.

that an employee who has AIDS becomes progressively ill, requiring increasingly frequent bouts of sick leave, generally over the last 12 to 18 months of their life. During this period, the individual remains on the payroll and cannot be replaced and is substituted by colleagues who act on their behalf, or by temporary appointments.

Sick leave policy is determined by the Local Authorities Act and Council employees are entitled to 120 days sick leave at full pay over any thirty-six month period, which can be extended by 120 days of sick leave at half pay over a thirty six month period.

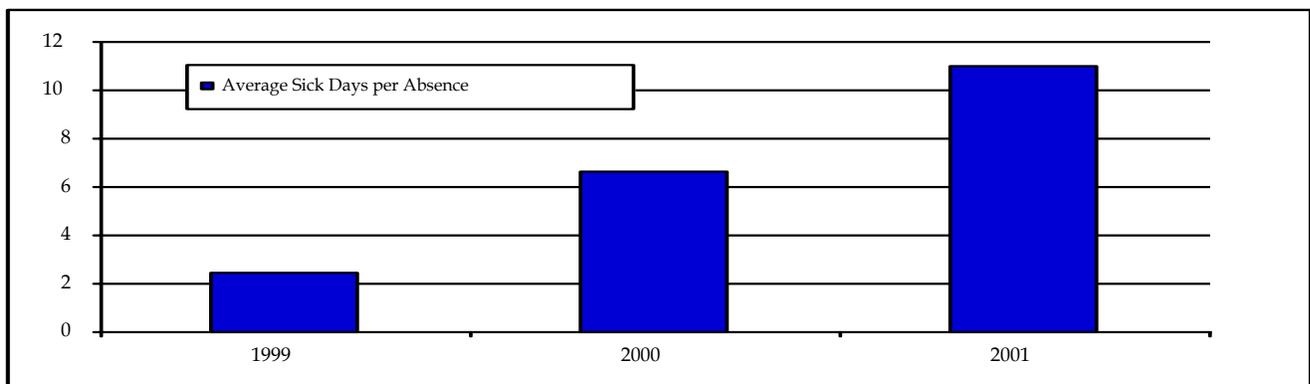
Over the period 1999 - 2001, the number of staff taking sick leave increased sharply from 9 individuals taking 23 days off in 1999 to 15 staff who took 159 days of sick leave in 2001, although the number of staff did not increase substantially. The following graph illustrates this trend.

Figure 4.3: Total Sick Leave Days by Year, Ongwediva Town Council (1999 - 2001)



Equally, the average number of days per sick leave taken by employees has increased over the three year period, from less than four in 1999 to over ten in 2001. Figure 4.4 below illustrates this finding.

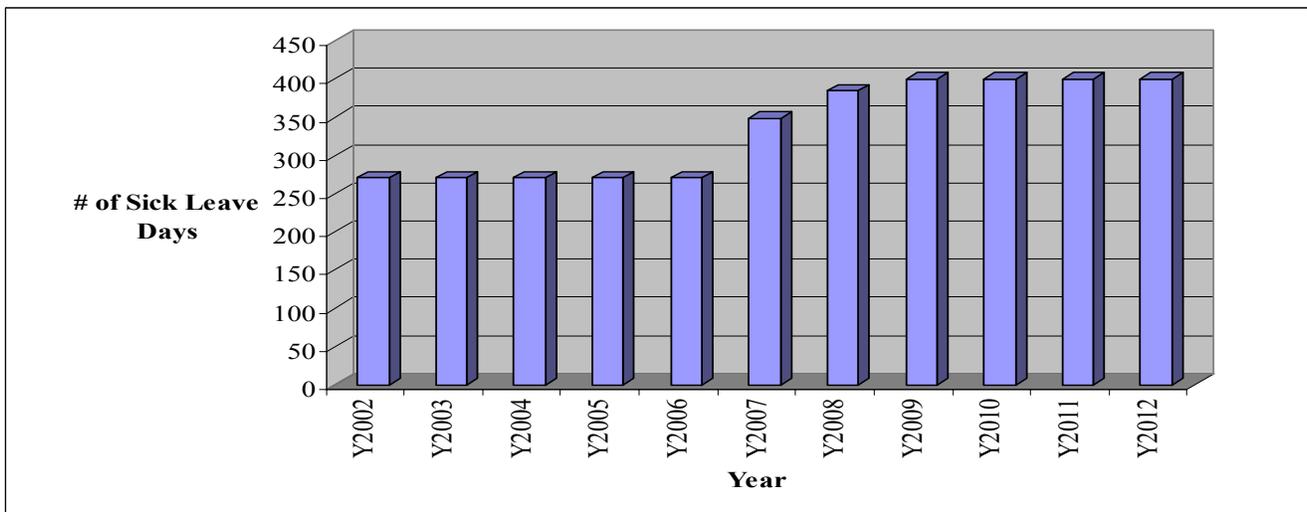
Figure 4.4: Average Number of Sick Leave Days per Absence, Ongwediva Town Council (1999 - 2001)



Ongwediva has in place a policy to cater for the chronically ill. This states that, if a staff member is continuously ill for six months, and if their full recovery is questionable on the basis of medical reports, the human resources department has two options. It may either grant two further periods of sick leave for up to three months each or a medical council may be convened to determine if the individual is permanently medically disabled in accordance with the respective provident or pension fund.

The AIDS epidemic will result in a substantial increase in the amount of sick leave taken by Town Council employees. Analysis of past sick leave days indicates that it will increase from 200 days in 2002 to 400 days per year by 2012 solely as a result of AIDS related illnesses, assuming the number of those employed by the Council remains constant. This analysis is based on the number of sick leave days taken by employees and recorded by the municipality. The average number of sick leave days taken has been increasing and is assumed generally to be a result of AIDS related illness as there have been no dramatic increases in the number of employees. From the demographic projections used in this report, it was possible to estimate the level of AIDS related illness over the period during which sick leave has increased. It was then calculated how many days of sick leave for those who were ill are likely to have taken to account for this increase in sick leave. This estimate was then used to project sick leave sick individual) to the number of estimated future deaths. This is illustrated in the following figure.

Figure 4.5: Estimated Increase in Sick Leave Days, Ongwediva Town Council (2002 - 2012)



Compassionate Leave

The Council permits employees to take compassionate leave. The allowance is three days per death up to a total of ten compassionate leave days per year. In addition, three days are allowed to care for a sick relative or other person. While no data were provided on the amount of compassionate leave taken by Municipal personnel, evidence from elsewhere in the region suggests that this is increasing exponentially.

Medical Aid

Membership of a medical aid plan is voluntary for employees of Ongwediva Town Council. Where employees are members, the Council pays 50% of the employee's monthly contribution. Council's monthly payments in this respect are only applicable to the employee as the principal member of the scheme, and their children. Certain AIDS medication costs (for opportunistic infections) are paid up to a monthly limit. The cost of medical aid to Council and to employees will rise as the number of those requiring AIDS medication increases.

Training

Council provides training to staff, subject to its policies. HIV/AIDS will increase the need for training of Municipal personnel, as employees are lost to the epidemic early in their careers. This then increases the costs of training and recruitment. Equally, the private and other sectors, offering higher salary and benefit packages, will increase the rate at which they "poach" trained staff as they in turn lose employees. This is likely to be particularly true for skilled Municipal staff and those trained to degree level. This, in turn, will increase the costs and frequency of training provided by the Municipality as it further increases staff turnover.

Municipal training policies, therefore, need to include strategies for maintaining and developing skilled staff. These have to be based on the provision of more frequent, but shorter-term training opportunities, within affordable cost parameters.

No data were made available on the costs of training by band. This needs to be obtained and integrated into the planning being undertaken by the Town Council.

Pension Fund

Employees of Ongwediva Town Council are members of the Retirement Fund for Local Authorities in Namibia. This fund operated as a defined benefit fund until 1992, when due to the large number of claims it changed to a defined contribution fund. This means that the amount paid to members' families on their premature death was reduced.

In April 2000, the fund further reduced the level of its death benefits, as these payments had become unsustainable due to the high number of claims, which were resulting in an increase in the cost of premiums.

Prior to April 2000, the fund provided a benefit payment equal to three times annual salary as lump sum at the death of a member, plus a monthly income of 50% of base monthly salary and 10% for five minors up to the age of 25, providing they were attending an institution of higher learning. Employers pay into the fund 21.7% of the employee's base monthly salary, of this amount 14% is used for investment, 6% goes to pay death benefits and 1.7% provides for the fund's administration. Employees contribute 10% of base monthly salary to the fund.

The current death benefit allows for a once off lump sum payment of 5.3 times annual salary at the death of a member, three differing options based on the level of guarantee and investment. This amount is not fixed and will be reduced if found to be too expensive.

The Retirement Fund for Local Authorities in Namibia Investment Report of 31 December, 2001, reveals that the fund had investments in Namibia and South Africa, and the market value totaled some N\$ 3.7 billion. The rate of return on these investments over the past 10 years was 16.3%.

As at the valuation date, the contribution rate required to cover the cost of risk benefits and other expenses, expressed as a percentage of pensionable salaries, was estimated as follows:

Table 4.1: Contribution Rate Required

Benefit Type	Percentage
Death Benefits	4.80
Disability Benefits	1.20
Total Risk Benefit Contribution	6.00
Expenses	1.70
Required Contribution Rate	7.70

The current contribution rate is therefore sufficient to provide for the risk benefits and the expenses. If, however, deaths increase while benefits and contributions remain constant, the required contribution for risk benefits will increase leaving less available for pensions.

In sum, the funds operate on the basis of defined contribution (as opposed to defined benefit), that is, the benefits received are determined by the amount of the contribution made by and on behalf of the employee, and the return on the investments made by the fund. This, while protecting the Fund for depletion resulting from the increased costs of AIDS mortality, does not reduce the cost of the epidemic. It merely switches these costs from the Fund to members, and the households and the communities in which they live.

The impact of HIV/AIDS has caused the fund to reduce the death benefits paid to members' families while increasing the cost to the members. This trend will continue as more members die from the diseases associated with AIDS and the death benefits claim continues to rise.

Critical Functions

Many of the costs associated with HIV/AIDS can be identified and, albeit with some difficulty, quantified. Many, however, are more difficult to determine and these less obvious costs and consequences may be larger and more important. These include the loss of institutional memory, the impact on staff morale, and the inability to perform critical functions as a result.

The Assessment attempted to identify critical posts through the key informant interviews. Those interviewed were first asked to identify essential and critical functions in their departments or sections. Following this, they were asked to identify the posts critical to achieving these functions.

In most instances, officials were able to identify critical functions. The identification of the posts (i.e., individuals) fulfilling these functions became more difficult. The epidemic will increase the demand for services across many municipal departments, but particularly those related to water, refuse removal, housing, etc. Attention will need to be paid to strengthening departments where increased service delivery will be required.

In the case of Ongwediva, managers were most concerned about their strategic management and planning functions. Managers, however, indicated that while the Council would suffer as it would not be able to manage the epidemic and build capacity simultaneously, the fact that it was small had advantages, as many of the line managers are capable of standing in for one another.

Governance

In Namibia, municipal and town council officers are democratically elected to provide service to their communities. They are thus the tier of government closest to the people they serve. The HIV/AIDS epidemic will impact on the process of local elections and the relationship between councillors and those they represent.

Firstly, councillors, as elected representatives, will be expected by their communities to lead the local response to the epidemic. This entails not only ensuring that the local authority manages and plans for service provision in the face of the impacts of HIV/AIDS, but that it actively develops and implements efforts to prevent infection and provide support to those who are infected at the grassroots level. As the impact of the epidemic deepens over the next

eight to ten years, the local electorate will demand that councillors respond. If they fail to do so, voters may become increasingly dissatisfied and may vote office-holders out of office, shift their support to other candidates, or even stop voting altogether.

Secondly, councillors themselves will not be immune from the epidemic. They too will be faced with the illness and death of relatives and friends, adding to their burden as elected officials. In addition, some will themselves be infected with the virus. Already, anecdotal stories and first-hand reports from countries in the region tell of HIV infection among senior officials, and local councillors cannot assume that they or some of their colleagues will not also be infected and become ill due to HIV infection.

Thirdly, the epidemic will reduce the resources available for municipal-level service provision, by reducing the tax base or redirecting resources to AIDS-specific programmes and services. This reduction in resources, combined with the reduction in capacity at the local level, will occur at the same time that the epidemic results in increased demands for local government support and services.

Fourthly, the epidemic has the potential to impact on the electoral process itself. AIDS could make elections more difficult and more expensive to hold, by affecting some of the officials and civil society representatives who administer elections, and by complicating the process of ridding voter rolls of those who have died as a result of the epidemic. In addition, residents may be less likely to vote if they are ill or occupied with caring for an ill family member. AIDS will also cause increased illness, retirement, and death of elected officials, which will result in more frequent by-elections, further increasing costs to the municipality. In addition, by-elections usually have much lower turnout than general elections, which means the officials elected in this way may have less support from, and connection to, individual voters and the communities that they serve.

Costs

In order to estimate the cost of the epidemic to the local authority a simplified model was developed as a guide to where the major costs of the epidemic will lie. The assumptions

behind these costs are discussed in Annex C to this report that contains the detailed costing tables, the notes and assumptions on each of the costing sheets used. Copies of the model have been made available to each of the local authorities, so that they can be used as an ongoing planning tool. The assumptions upon which the following figures are based will need to be updated and modified, as improved data becomes available.

The main internal costs lie in increased absenteeism, medical aid contributions and lost productivity.

For Ongwediva, the main costs will lie in increased absenteeism, medical aid contributions and productivity losses. Over the nine year period (2002 - 2010) the present value cost solely due to the HIV/AIDS epidemic will be N\$565,230 across all bands. The following table provides data on these increased costs by band. The figures are discounted totals, i.e., are shown at present value.

Table 4.2: Total Increased Costs Resulting from the Epidemic by Band, Ongwediva Town Council (2002 - 2010)

Band	2002	2003	2004	2005	2006	2007	2008	2009	2010
All Bands	65,749	62,805	59,963	57,192	54,510	64,604	70,107	66,744	63,556

The following table present the breakdowns for the figures contained in Table 4.1 above. The detailed working table, explanations and calculations, etc. are presented in Annex C to this report. It should be noted that the mortality rates and sick leave data used are taken from data contained in the two previous chapters of this report.

Table 4.3: Total Increased Costs Resulting from the Epidemic on all Bands, Ongwediva Town Council

Year	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Deaths	2	2	2	2	2	2	3	3	3	3	3
Sick leave											
Days	271	271	271	271	271	349	401	401	401	401	401
Cost	46365	46365	46365	46365	46365	59659	68521	68521	68521	68521	68521
Compassionate leave cols	684	684	684	684	684	684	1026	1026	1026	1026	1026
Productivity	7741	7741	7741	7741	7741	10617	11611	11611	11611	11611	11611
Recruitment	623	623	623	623	623	623	935	935	935	935	935
Training	1994	1994	1994	1994	1994	1994	2991	2991	2991	2991	2991
Sub total	57407	57407	57407	57407	57407	73576	85084	85084	85084	85084	85084
Benefit increase	6546	6546	6546	6546	6546	6546	6546	6546	6546	6546	6546
Compassionate leave family	1796	1993	2157	2254	2304	2331	2320	2286	2272	2243	2252
Bad debt	0	0	0	0	0	0	0	0	0	0	0
Sub total	8342	8538	8703	8800	8850	8877	8866	8832	8817	8789	8798
Total	65749	65945	66109	66207	66257	82453	93950	93916	93902	93873	93882
Discounted total	65749	62805	59963	57192	54510	64604	70107	66744	63556	60512	57636
Present value cost	683378										

External Impacts

The municipality is not an isolated institution. The impacts on the municipality will have implications for the wider community, just as those on the wider community will impact on the municipality.

Firstly, the economic impact of HIV/AIDS in Ongwediva may affect the Council's revenue. The revenue of the municipality is generated primarily through the collection of rates and the sale of erven as well as the provision of water, electricity, sanitation and sewage services, which collectively account for over 70% of revenue.

Rates are an important source of income. Ratepayers can be divided into the private sector and households. While there will be a negative impact on the private sector, for larger business owners rates are unlikely to be a major cost component in their business operation and their ability to meet this obligation should not be affected. For small business and the informal sector, both of which are important in Ongwediva, the ability to pay for services could be affected. As discussed previously the structure of the economy in the region makes households and the business they support vulnerable to the impacts of HIV. For small operations a decline or change in demand coupled with the possible pressure of illness among employees and owners could seriously constrain budgets, and municipal service may be one of the expenditure items to suffer.

Similarly, at the household level the impact of the epidemic could affect their ability to pay rates. In addition, as the death rate increases it is likely to cluster in households and create a series of economic shocks over several years. These latter households will be increasingly unlikely to be able to pay for services over several months.

The sanitation, sewerage and water services are run on a policy of no profit - no loss. Therefore, while the performance of the economy and the growth rate of the city may affect the level of demand for these services, this should do little to the financial position of the

municipality. This is because any change in revenue should be accompanied by a similar change in expenditure. A similar impact to that relating to rates concerning ability to pay for these services may, however, present itself.

With regard to water service, it should be noted that growth in demand will increase less rapidly than in the past as a result of slowed and reduced population growth. However, in AIDS-affected households which are caring for the sick and dying or looking after orphans, short-term per capita consumption of water will increase, while their ability to pay for this service will decrease.

Electricity provision is, however, different. Electricity was until recently wholly sourced via the Council. However, supply is now provided by NORED, a company in which Council (together with three other local authorities) is to acquire shares from which it anticipates receiving dividends. These profits are now projected into future Council budgets at over N\$1 million per annum. However, it is likely that overall electricity sales will be related to the performance of the regional economy. Any factor, such as AIDS, that depresses the growth of this economy will depress the growth in demand for electricity and therefore increases in expected revenue from these dividends. The performance of the economy will, therefore, influence the revenue of the council mainly through its impact on reductions in electricity demand. Ability to pay for electricity at the household level will also become an issue.

Land Sales

The sale of land and houses is an important source of revenue for the municipality. HIV/AIDS, however, will affect these sales in a number of ways complicating the achievement of delivery targets and interfering with revenue flows. If land or property is purchased from the municipality with no financial ties between the buyer and the municipality existing after the sale, there will be little impact as a result of the epidemic. The possible exception would be that house and land prices and the health of the market will be indirectly affected by HIV/AIDS via the epidemic's impact on the local and regional economy, but this impact is by no means certain.

If, however, the municipality finances the sale of property or they administer that finance, there will be impacts. A loan agreement involving the municipality in any way means that the council will be involved if the owner dies. If the municipality administers the loan there will be an increase in the costs associated with processing and dealing with that death. In cases where the municipality finances the sale itself than there will be an increase in administrative costs, possible loss of revenue and a decline in profitability.

Administrative costs will rise as deaths increase as changes in the financial arrangements will have to be processed or repossessions conducted. For example, in the case where upon death of the house or plot owner a substitute beneficiary purchaser is identified, the agreements will have to be amended to reflect this change.

In the situation where the sale is financed by the municipality itself, there is a risk that the council will lose revenue as payments stop. While many of the agreements include life insurance cover, this will become more expensive and, as deaths increase, this cover will become more difficult to arrange, especially for low income groups. If the amount outstanding is uninsured at the time of death and no substitute purchaser is available the council will be faced with writing off the debt or repossessing the property which itself can be expensive. This may be further complicated if a household is left impoverished by the impact of AIDS or contains orphans.

Even if outstanding debt is covered by an insurance policy, death will decrease the profitability of sales. Sale of property generates revenue in two ways, firstly through the capital payment and secondly through the interest received. Insurance protects the capital, but early payment following a death means the loss of interest income for the remaining years of the loan.

From the information provided by the municipality, it is not clear as to what degree the council is directly involved in financing or simply administering house and land sales. Either way HIV will increase costs and, if the municipality is involved in financing, it may also lose capital.

Household Level Impacts

The other major impact on revenue results from household economic impacts and ability to pay for services. Studies elsewhere in Africa (Tanzania, South Africa, and others) have found that the greatest impact on the household occurs just after death. After the long financial strain of recurring illness, the household is faced with the cost of burial. At this stage households find it difficult to meet other expenses. The impact on municipal revenue resulting from household impacts will largely be determined by two factors: 1) which expenditures are sacrificed by the household when these financial problems occur; and 2) if these expenditures include payment for services what the Council response will be.

At present, the Council provides services to some 2,650 households. It is not possible to determine the number of households likely to be infected or affected by HIV/AIDS. However, the epidemic will not be spread evenly across all households, it will cluster, and because the disease often co-varies with educational levels and poverty, it will also not be spread evenly throughout all neighbourhoods.

Further, while household ability to pay for some services will be constrained, their willingness to pay for these remains unknown. This can only be assessed through household level quantitative surveys, which are beyond the scope of this assessment. However, it may be that those suffering AIDS-related economic shocks would be willing to pay for Municipal services, sacrificing other items in their household budget.

If the household has to reduce or redirect expenditure, but elects to cut back on other products and services than those provided by Ongwediva Town Council there will be no impact on revenue. If, however, households stop paying for some or all services provided by the municipality, the impact on revenue will be affected by the response of the municipality to this non-payment. If, for example, a household was unable to pay for a service, the response would be disconnection. This makes it more difficult for the household to recover

from their financial crisis, as they are now faced with both debt and reconnection charges, and during the period of disconnection the municipality makes no profit. Alternatively, the municipality could offer a one to two month reprieve from payments for a short period of time following a death, reducing the financial pressure on the household. This would result in fewer disconnections, reducing these costs. Once this period has passed the household could resume payments. In the long term this may be more financially beneficial to the household and the Council as the profits associated with disconnection are not lost.

An additional concern for Ongwediva related to household impacts is related to the municipality's sale of land. This source of revenue will also be very closely related to the rate of growth of the town. Therefore, as growth slows so does the rate of revenue increase. While it appears that most of these sales are financed through commercial banks or building societies, or in the case of low-income buyers, the Build Together Project, and that all these loans are insured, more defaults can be expected. While Council will be protected from losses on the sales themselves, the land sold will pass to beneficiary households who may be unable to pay the loans, and to pay for services on the erven itself. Over time, rating and service revenue will decline as a result.

The above discussion has focused on the possible impacts of the epidemic on revenue *levels*. A related and important issue is the impact on revenue *growth*. All major sources of revenue are related to the size of the city, in terms of area and population. In the demographic section of the previous chapter, the slowing in the rate of population growth was discussed. This slowing in population growth will translate into a reduction in the rate of revenue growth. However, growth in expenditures is also slowed and the net financial position of the municipality should be relatively unaffected.

There is, however, one possible set of financial impacts associated with slower growth. The staff and productive capacity of the municipality has to increase as the city grows. If the rate of increase in staff and productive capacity is based on previously projected population growth rates for the city, then expenditures will increase faster than revenues. To prevent

such an occurrence it is essential that planners include the impact of the HIV/AIDS epidemic now, as any increases in capacity, say for water or electricity provision, involve long term planning. This is particularly important in small towns, such as Ongwediva, where investments, such as a new sub-station, are a significant cost item.

Equally, the demand for burial space and cost associated with its allocation, preparation and maintenance will increase as the death rate climbs and will need to be planned for. How great such an increase will be is difficult to estimate. Many residents of Ongwediva are migrants from elsewhere in the north of Namibia. They may well opt to return home while ill and die outside of the town. Equally, there are residents of the town who are migrant workers elsewhere in Namibia, who may return to the town when they become ill. Unfortunately, without a proper socio-economic profile of Ongwediva, the extent to which either case applies is not known.

The HIV/AIDS epidemic will impact not only on the revenue of the municipality, but also on the level and pattern of expenditures. Firstly, the council is a large employer in the town and will therefore experience the associated increasing cost of labour. The magnitude and implications of these increasing costs was discussed earlier in this chapter. Clearly, the expenditure of the municipality will increase, while no increase in revenue is generated.

The above discussion has focused on existing revenue flows and services provided. The HIV/AIDS epidemic poses new problems and the municipality will be called upon to respond to some of these. One such implication is likely to be changing housing demand. Within ten years there will be over 1, 300 orphaned children in Ongwediva. Planning for their housing needs will require the introduction of differing planning designs and standards. The introduction of these and other new services obviously have cost implications.

The Municipal Response

In completing this Assessment, concern regarding the impact of HIV/AIDS on programmes and service provision was expressed by Council officers. However, mitigation plans in

response to these impacts are not yet in place, nor does the Council have an AIDS in the Workplace Policy or Programme. This Assessment is intended to assist in addressing these gaps.

The Town Council is to construct a Multi Purpose Centre which will house HIV/AIDS prevention activities, together with the community library, and other facilities. Donor funds are being provided, and Family Health International is supporting this initiative.

Knowledge, Attitudes and Practice

Most of the Council personnel interviewed had correct information regarding HIV and AIDS and how the virus is transmitted. Some expressed doubts about the disease being new, saying, 'it was something that had been known in the past', but most did not.

"AIDS is like a black mamba snake...once it bites you, you will just die instantly. The same goes with AIDS." FGD Participant, Ongwediva.

Close to half of those interviewed indicated that they knew of someone who had died of AIDS, generally a relative or colleague. As a result, all participants felt that HIV/AIDS was a serious problem in Namibia because 'it is killing the youth and productive people'. However, participants believed that many sectors within Namibian society did not want to get involved in HIV/AIDS, as they believe that 'it is a problem for the Ministry of Health and Social Services'.

In responding to a series of attitudinal statements about HIV and AIDS, participants all indicated that they believed people within Ongwediva Town Council were likely to be infected, that people with AIDS should not be isolated, but indicated that stigma remained a problem as households caring for individuals with AIDS might be isolated by community members.

Participant responses to these questions, and the reasons for their answers, are presented below.

Table 4.4: Attitudes among Council Employees

Statement	Agree	Disagree
Question: "I don't think that there is anyone in our local authority who has the AIDS virus."		All
Reasons for "disagree": <ul style="list-style-type: none"> It would be impossible to have no one in the local authority infected 		
Question: "There is a serious problem of 'sugar daddies' in our community."		All
Reasons for "agree": <ul style="list-style-type: none"> 'Sugar daddies' have money and nice cars, and they are usually night club goers, where they pick up young girls who are still in school There are many 'sugar mummies' especially school teachers, nurses and top government employees 		
Question: "If someone is known to have the AIDS virus, they should be isolated."		All
Reasons for "disagree": <ul style="list-style-type: none"> Isolation of AIDS positive people will not be effective because such a person needs moral support, love and care It might be a good idea to create a room for AIDS positive people in the hospital, because some are isolated by their families once they get AIDS 		
Question: "Households that are taking care of an AIDS patient are avoided by other households."	2	8
Reasons for "agree": <ul style="list-style-type: none"> People are afraid of being infected themselves Reasons for "disagree": <ul style="list-style-type: none"> Affected households need the support for other family members or friends 		
Question: "A number of people believe that they can be cleansed of the AIDS virus if they have sex with a virgin."		All
Reasons for "disagree": <ul style="list-style-type: none"> It is because of this mentality that many girls especially young babies are being raped "It is the traditional doctors who are telling people that they can be cured if they have sexual intercourse with a virgin. These doctors should be put in jail for what they are doing." 		
Question: "If a woman wants to use a condom but the man does not, the man's decision should rule and they should still have sex."		All
Reasons for "disagree": <ul style="list-style-type: none"> Men should not have the only decision-making power Women should have the power and authority to make such decisions 		
Question: "If one is in a long-term relationship, it is really impossible to refuse sex, including sex without a condom, even if you fear that they have a sexual infection."	15	1
Reasons for "agree": <ul style="list-style-type: none"> It is true because if one partner, especially the women ask that a condom be used that a quarrel can start Men who work away from home, are the ones who bring diseases home Reasons for "disagree": <ul style="list-style-type: none"> If a couple has been in a relationship for a long time, then there should be mutual trust, and they should be able to listen to one another 		
Question: "If a shopkeeper has the AIDS virus, I would still buy products from them, including fresh produce."	11	2 maybe
Reasons for "agree": <ul style="list-style-type: none"> "I will continue to buy from such a shop, unless I hear rumours that the infected person is bribing people. The bribe could be that the infected person threatens people that he/she would put her infected blood in the food sold in the shop." AIDS cannot be found in food stuffs, so he would continue to buy at such a place Some of the people who work at restaurants are infected, but people still go there Reasons for "disagree": <ul style="list-style-type: none"> "I would not mind if the person sell things which are covered in plastic bags or something else, but I would have a problem if such a person works in a restaurant" 		

Intervention Activities

Interviewees were asked to discuss ideal intervention activities, which could be introduced by Council. Participants felt that the Council should do more to prevent infections among both its staff and the community it served. Most participants believed that the design and implementation of these activities was the responsibility of senior management within the Town Council, and that specific staff should be designated to co-ordinate AIDS awareness and support for those already HIV-positive. However, there was a strong belief that leadership and a clear commitment, not only by Council management but also by elected leaders and other stakeholders in the community, would be needed to develop locally acceptable and successful interventions. The first step in making this happen, according to participants in both the SWAG and FGD exercises, was education of their leaders and key stakeholders in the town.

Condoms

Participants felt that people should be educated on how to use condoms. 'Condoms should be distributed in every *cuca* shop and in every shebeen, because these are the places where people meet and where alcohol is misused, leading to unprotected sex'. 'Some employees should receive training on how to use condoms so that they can teach others at the municipality'. Only a few advocated against improved access to condoms, arguing that this would promote promiscuity.

Awareness Raising

Respondents recognised that there were many organisations currently providing information, such as Catholic AIDS Action. However participants felt that those involved in campaigns and promoting awareness should be educated and know what they are talking about. 'Awareness campaigns should allow for individual sessions to have more in-depth discussions'. Awareness campaigns should be extended to the families of municipal employees.

"Many people are aware of HIV/AIDS. They need to be taught the seriousness of it."

Financial Support

One respondent felt that a trust fund should be established to assist infected people within the municipality, but also the larger community. 'This type of trust fund should be extended to the entire country'. 'For Ongwediva a committee needs to be established, with a treasurer that will handle the fund'. The Council currently has an emergency fund. Other participants stated that financial support should become part of the HIV/AIDS policy and that the municipality should assist with the implementation of any policy developed within the Council to combat AIDS.

Interventions to Reduce High Risk Behaviours

One respondent felt that the Town Council should serve as the ambassador of the town and that this would include providing information on high-risk behaviours and how these are linked to high infection rates. 'Alcohol abuse can lead to HIV/AIDS infection, because people tend to be less careful with their actions when under its influence'. 'Education programmes on risky behaviours should be promoted and be part of awareness campaigns'. 'Peer educators should spend time with people who work away from their wives and partners and be informed on how to deal with the situation'.

Political Will

Participants believed that both employees and employers needed to understand the seriousness of the HIV/AIDS problem and that leaders of the municipality must become more involved.

"People must be involved in decision-making. If high-risk behaviour people are involved in developing interventions, then such interventions would have a better chance to succeed". SWAG Participant, Ongwediva. "

Leaders, including political leaders, were seen as very important in the fight against HIV/AIDS and in changing in people's attitude and behaviour.

Testing, Counselling and Treatment for HIV Positive People

Testing, counselling, and treatment were seen as an important set of interventions 'because if someone knows that there is treatment for his/her disease then such a person is more likely to come forward to voluntary testing'. Respondents felt that, ideally, such an intervention should be part of the Multi Purpose Resource Centre which the municipality is planning to establish. 'Ideally people should not be forced to be part of the programme, rather they should go out of their own free will'.

Destigmatisation

One participant felt that stigmatisation would always be part of people's lives as long as the disease is linked to sex. It was therefore felt to be important that people seek counselling to help them deal with stigmatisation. Other participants believed that people should be made aware that HIV/AIDS is not contagious like TB, because one can share food and utensils with an HIV infected person. One participant felt that 'the only reason why there is a stigma towards HIV/AIDS is because people are not well informed, and because they are afraid'.

"Only those who are infected and come forward to declare their status would allow others to accept the HIV/AIDS situation and as a result decrease the stigmatisation cloud that hangs over us " SWAG Participant.

Chapter 5: The Way Forward

Introduction

This final chapter is based on the proceedings of the Strategic Response and Action Planning Workshop held in Walvis Bay from 12 - 16 August 2002, and attended by elected councillors, including mayors, management and other officials from each of the five local authorities. The purpose of the workshop was to assist each municipality develop *draft* multi-sectoral and integrated plans preventing future infections and mitigating the impact of HIV/AIDS on their city or town. The agenda, minutes of proceedings and workshop attendance list is included in Volume 7.

The process involved developing a common understanding and agreement of the impacts of HIV/AIDS on the five cities, agreeing a strategic response and, finally, participants from each local authority began developing plans to prevent and mitigate the epidemic in their own city. It should be noted that the plans developed for each local authority are drafts, and will require consolidation and expansion, prior to their submission through senior management to Council for approval.

The Planning Process

The planning process involved

- reviewing the draft Impact Assessment reports (including ensuring their accuracy, and recommending suggested changes);
- developing a common understanding and agreement of the impacts of HIV/AIDS on the five cities;
- agreeing the elements of a strategic response;
- identifying the data and information needs in order to inform this response; and
- developing draft plans to prevent and mitigate the impacts of the epidemic in their own city.

It should be noted that the plans developed for each local authority are *drafts*, and will require consolidation and expansion, prior to their submission through senior management to the respective Municipal or Town Council for approval.

Strategic Response

Participants agreed that an appropriate strategic response by each local authority would encompass:

Management Strategies

Management strategies are intended to assist the local authority identify, plan for, mitigate and monitor the impacts of the epidemic on its personnel and operations.

Internal Strategies

Internal strategies are intended to enhance knowledge and understanding of HIV and AIDS among municipal employees and reduce future infections through prevention activities built on this knowledge. They are centred on the development, approval and implementation of Workplace Policies and Programmes.

External Strategies

The external environment refers to the impacts of HIV/AIDS on the community served by Ongwediva Town Council. The intention of these strategies is to widen the municipal response to the epidemic through enhanced linkage with and support to existing government and non governmental organisation programmes and activities.

Based on these three strategies, the participants from Ongwediva then developed the following goal to guide and inform the town's strategic response to the epidemic:

GOAL: To reduce the incidence rate in Ongwediva

Data Needs

Detailed lists of the information and data required to plan for the epidemic's impacts and to inform prevention activities were discussed and developed at the Workshop. These included:

- data needed to inform management responses to the impact of the epidemic, for example those relating to absenteeism, personnel profiles, critical posts, etc.;
- data needed to measure and monitor the epidemic's impact on the city such as that relating to its economic performance, municipal revenue, etc.; and
- data needed to expand the municipal prevention response both internally and externally. This included Knowledge, Attitudes and Practices studies data on other providers of prevention and support services among the wider community, for example.

Data sources for this information were discussed, and a detailed list of these is contained in the minutes of the Workshop proceedings. However, in this regard, the importance of collecting adequate data within local authorities should not be under-estimated. This is especially pertinent with regard to the human resource management systems presently in place within each local authority. While most are able to provide the basic data needed to monitor the epidemic's impacts on personnel (i.e., that relating to absenteeism), with the exception of Swakopmund, none are disaggregating leave by type and none are costing these absences. Some, such as the used by Windhoek Municipality, are recognised as being user-unfriendly and needing modification in order that internal indicators of the impact of epidemic can be monitored on a monthly basis.

Equally, no municipality is monitoring the impact and cost of AIDS related illness and death on benefit programmes and their costs. These need to be monitored annually.

Action Plans

Each municipality then developed its own plan covering the three elements of the agreed strategic response. Each strategy area has several objectives, and for each of these a detailed

list of activities was developed, the person or persons responsible for the activity were designated, the time frame established, outputs identified and budgets estimated. The detailed draft plans developed for Ongwediva are contained in an Annex B to this report.

The Way Forward

Following the workshop, deadlines were set for the receipt of additional comments of the draft and will lead completion of the final report. At this stage the Assessment of the Impact of HIV/AIDS on Ongwediva is to be presented through its management structures to Council for approval and action. However, the draft plans included in the final report will require further elaboration and, perhaps, amendment, by local authority officers prior to their presentation to management and subsequently to Council for agreement and approval.

However, Family Health International (FHI), through whom the funds for this Assessment have been provided, has agreed that the remaining, *limited*, funds under the SIAPAC contract *may* be re-programmed, subject to availability. The intention is to support activities related to the acceptance, initiation and implementation of findings and recommendations (as contained in the plans) resulting from this Assessment by the local authorities. Requests for the use of these funds are to be made in writing to FHI through SIAPAC for approval. The types of activities suggested for the use of the remaining funds are further workshops presenting the findings from the Assessment and the draft plans to senior managers and Councils at the local level, additional data gathering exercises to supplement findings from the report or further planning exercises, etc.

Beyond these activities, additional strengths and resources are to be found within the network of local authorities in Namibia, through the national associations (NALAO and ALAN). Equally, AMICAALL can assist in developing and implementing the plans to mitigate the impacts of HIV/AIDS on each municipality. It is the responsibility of the appropriate representatives within each local authority to present the findings of the reports and the plans to mitigate the impacts of HIV/AIDS to these national associations as well as other bodies.

Annex A: Active HIV/AIDS Organisations

The following AIDS Support Organisations (ASOs) are listed as operating in the Ongwediva area and/or in the Oshana Region.

Name of Organisation: AIDS Law Unit (LAC)

Programmes

- Litigation and legal advice,
- Lobbying and Advocacy
- Policy Formulation,
- Development of Training and Educational materials

Name of Organisation: Alliance of Mayors and Municipal leaders on HIV/AIDS in Africa (AMICAALL)

Programmes

- The programme aims to strengthen capacity to reduce the social and economic impact of HIV/AIDS on urban and peri-urban centres, with particular focus on heavily affected countries in sub-Saharan Africa by supporting the development of local government/civil society partnerships; creating capacity for scaling up multi sectoral responses; sharing knowledge and lessons about what works across countries contributing to the development of a supportive policy environment that reflects the rights of those affected and is gender sensitive; stimulating twinning and other partnerships to enhance solidarity across borders; and promoting innovative approaches to resource mobilisation for community based initiatives.

AMICAAL is the strategy adopted by the Alliance to translate its goals into concrete options in countries and communities. The overall goals of AMICAAL are to develop and implement multi-sectoral responses to the HIV/AIDS epidemic at the local level via a consultative process between Civil Society and Community leaders and achieve local capacity. It calls for a locally fed, multi-sectoral approach that complements and supports national policies.

Name of Organisation: Catholic AIDS Action (CAA)

Programmes

- Implement a modified programme for Primary schools – Stepping Stones,
- Motivate and implement youth-prevention oriented programmes such drama groups, peer-support and establish Anti AIDS Clubs in Roman Catholic affiliated parishes and schools,
- Recruit and train volunteers for spiritual support, counselling, home-visits, caring and supporting sick ones and orphaned children,
- Ensure a demonstrated commitment to HIV/AIDS awareness and prevention through periodic sermons, distribution of literature and group meetings.
- Offer support for local self-help Groups and activities,

- Soup kitchens for HIV/AIDS patients, orphans and vulnerable children,
- Initiatives in living positively and caring for ourselves in order to care for others,
- Income generating activities and limited direct (welfare) support,
- Undertake community education and outreach programmes,
- Implement annual Training of Trainers (ToT) programmes in Home Based Care and Psychosocial supports,
- Host annual Conferences (both at national and regional level).

Name of Organisation: Council of Churches in Namibia (CCN)

Programmes

- Conduct faith justice and society programmes
- HIV/AIDS educational campaign,
- Conduct Violence against Women and Children Workshop,
- Operational Voluntary testing Centre, with cost involved
- Marriage counselling

Name of Organisation: Farmers Against HIV/AIDS and STD's (FAHA)

Programmes

- Training of Volunteers as Home Based Care Givers in selected farming communities,
- HIV/AIDS information development and dissemination with primary focus on the farming sector,
- Community mobilisation Workshops on HIV/AIDS,
- Hotline and Self-help corner on HIV/AIDS and other related STD's,
- Condom distribution within the farming communities

Name of Organisation: Hope Namibia

Programmes

- Organise campaigns in the north western regions of Namibia in order to reduce the HIV/AIDS infection rate,
- Condom distribution
- Drop-In Centre,
- Training of Health workers,
- Training of Peer Educators by using Stepping Stones Guidelines,
- Provision of Voluntary Counselling and Testing,
- Home Based Care Training,
- Carry out operational research,
- Community outreach programmes.

Name of Organisation: Katutura Youth Enterprise Centre (KAYEC)

Programmes

- Conduct livelihood HIV/AIDS Training to rural young men and women aged 15 - 30 years for self-employment,
- Offer vocational Training courses in Bricks Laying and Plastering, Carpentry and Joinery, Plumbing and Pipefitting and Metalwork and Welding,
- Business Training courses,
- Computer Training courses,
- Youth Leadership

Name of Organisation: Lifeline/Childline Namibia

Programmes

- Lay counselling hotline services (7 days per week - 15 hours per day)
- Face - to - face counselling,
- Training of prospective Volunteer Counsellors,
- Childline Schools programme (12,000n Primary school children per annum exposed to Life Skills educational drama. Skills in areas of sexual abuse molestation, domestic violence and HIV/AIDS).
- Life Skills Training in Communities on variety of subjects,
- Facilitation of sustainable community development programmes with focus on emotional health and counselling services,
- Networking with government Ministries and other bodies to enlarge the resource pool for people in emotional need,
- Fundraising activities to sustain all these services.

Name of Organisation: Namibia National Network for people living with HIV/AIDS (NANNP+/LIRONGA EPARU)

Programmes

- Mitigate for the rights of PLWHA,
- Provision of information, education and communication (IEC) materials on HIV/AIDS,
- Administer Bursary Fund for PLWHA - long term object of the Network,
- Provide Counselling and Home Based Care to people living and affected by HIV/AIDS and if need be refer to suitable Counsellors,
- Offer Empowerment, self-reliance, self confidence and motivational training courses for PLWHA,
- Advocate for access to treatment, care and support for PLWHA,
- Undertake annual regional visits to selected regions in order to build the capacity of regional structures,

- Advocate to policy makers and politicians on matters of different impact to PLWHA, such the introduction of PTCT programme – (parental-to-child-transmission),
- Income generating projects to support orphans and for self-sustainable.

Name of Organisation: Namibia Planned Parenthood Association (NAPPA)

Programmes

- Condom distribution,
- Information dissemination pertaining to sexual and reproductive health,
- Educational provision on family planning,
- Development of IEC material for public use,
- Implementing a 5-year UNFPA funded project to provide SRH information and Service to youths in-and-out of school in the Ohangwena Region,
- Establishment of Youth Clubs in schools.

Name of Organisation: Namibia Students’ Education Movement (NASEM)

Programmes

- Fostering pf parents’, students and teachers co-operation amongst various educational institutions,
- Advocate for abstinence as the best option of alternatively condom use and adherence to moral values and social ethics,
- Conduct various students’ rights and obligations workshops,
- Leadership capacity building workshop for Learners and Students’ Representative Council,
- Career guidance and motivational workshops for learners,
- Crisis intervention and mediation at school level,
- Participation in policy formulation with relevant stakeholders with emphasis on education and affecting the youth and the entire nation at large.

Name of Organisation: NaSoMa

Programmes

- Development of Behaviour Change Communication (CBC) materials as part of HIV/ AIDS prevention approach,
- Offer training on the correct usage and consistent of both the male and female condoms,
- Build an infrastructure for implementing a Namibian managed social marketing programmes,
- Set up a countrywide distribution and sales network for male and female condoms,
- Promote and market both the male and female condoms ensuring that products are always available, affordable and easily accessible to everybody.

Name of Organisation: National Union of Namibia Workers (NUNW)

Programmes

- Collective bargaining activities,
- Dispute negotiation, resolution, mediation and prevention,
- Arbitration.

Name of Organisation: Peer Education and Counselling Project (PECP)

Programmes

- Face to face counselling,
- Helpline telephone counselling,
- Training of Community AIDS Educators and Counsellors,
- Establish Regional Community HIV/AIDS Committee select and train HIV/AIDS Community Educators,
- Condom distribution at strategic places in and around Windhoek.

Name of Organisation: Sister Namibia

Programmes

- Conduct research on the socio-cultural constructions of masculinities, feminities and sexualities as a basis for developing pilot materials for comprehensive sexuality education in Namibia,
- Advocate and lobbies for full representation and participation of women in politics and governance,
- Provide training to women in rural and marginalised urban communities on the Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW) and women's rights,
- Conduct discussion events on topical issues of concern to women,
- Collect and hosts regional and international materials on women and gender issues

Name of Organisation: True Love Waits (TLW)

Programmes

- Advocate for minimal teenage pregnancies and early parenthood,
- HIV/AIDS Information dissemination to the public meetings, school visits, shebeens and at squatter areas,
- Peer education and counselling,
- Regular radio talks in at least three indigenous languages,
- Encourage young people to opt for abstinence until marriage,
- Conduct radio talks,

- House to house visits to educate the public on the transmission of HIV/AIDS as well as the prevention methods thereof.

Name of Organisation: Woman Solidarity

Programmes

- Offer talks, workshops and seminars to secondary schools students' with emphasis on violence against women,
- Telephonic and face to face counselling,
- Carry outreach programmes in a form of workshops and educational talks at schools and work place in order to raise public awareness thus ultimately reducing violence resultant HIV/AIDS infections,
- Offers support to women who were abused, sexually, physically or emotionally,
- Crisis intervention through a third-party,
- Advocacy and lobbying, networking and research into woman abuse and rape.

Name of Organisation: Young Women Christian Association of Namibia (YWCA)

Programmes

- Peer Counselling,
- Conducts HIV/AIDS drama performance,
- Run and manage needlework classes,
- Provide counselling to teenage mothers,
- Provide Pre-and primary education,
- Conducts literacy programmes, Income generating projects (vegetable garden)

**Annex B:
HIV/AIDS
Prevention,
Response and
Action Plans**

ONGWEDIVA: MANAGEMENT STRATEGY

STRATEGY AREA: Data Collection and Analysis (Internal and External)

OBJECTIVE: To collect and record data, compile and utilised information

INDICATOR: Internal and external analysis of data by February 2003 and thereafter an ongoing process

No.	Activities	Responsible Person Lead unit	Other Partners	Time frame	Output	Budget	Fund- ing Source	Technical Assistance
1.	Collect and Compile available Data	HIV/AIDS Co-ordinator	MOHSS	Nov. 02 - Jan. 03	Data Collected and Compiled	—	—	Task Force
2.	Analysis data and inform Internal and External Sector	—	HIV/AIDS Task Force	End of Feb. 03	Data Analysed and Information Shared	—	Payment of Data Analysis	Data Analysis
3.	Identify gap for further research	—	Management Team	Beginning March, 03	Researched Identified	—	—	—
4.	Conduct research and Analysis and Share Information	*	MOHSS	**	Research Conducted	***	—	—

NOTES: *It may require external researchers or MOHSS

** Will be determined depending on data needed and

***To workout depending on data needed.

ONGWEDIVA: MANAGEMENT STRATEGY

STRATEGY AREA: Baseline and Periodic Assessments

OBJECTIVE: To Generate a Picture of the epidemic currently and in the future

INDICATOR: HIV/AIDS Profile of the town Described and Disseminated to Stakeholders

No.	Activities	Responsible Person Lead unit	Other Partners	Time frame	Output	Budget	Fund- ing Source	Technical Assistance
1.	Review the Impact Assessment Report and Identify the gaps (e.g. prevalence rate)	Deputy Mayor	—	Beginning Sept. 02	Draft been reviewed, adopted and identify gaps	—	—	EHO
2.	Task the Co-ordinator to Collect and Report on missing information	Management Committee	Community	End of Sept. 02	Report	—	—	HIV/AIDS Co-ordinator
3.	Assess the Impact every two years	The Mayor	Line Ministries and HIV/AIDS Agency	Every two year	Impact Assessment	—	—	HIV/AIDS Co-ordinator
4.	Disseminate Information to key Stakeholders (Internal and External)	HIV/AIDS Co-ordinator	Management Team and HIV/AIDS Agency	Every financial year	Risk profile establish	—	—	External Consultant

ONGWEDIVA: MANAGEMENT STRATEGIES

STRATEGY AREA: Structure and Planning								
OBJECTIVE: To establish and mandate structures to plan, implement and monitor the town's HIV/AIDS responses								
INDICATOR: Appointment of the HIV/AIDS Co-ordinator and the municipal response to HIV/AIDS activities								
No.	Activities	Responsible Person Lead unit	Other Partners	Time frame	Output	Budget	Fund- ing Source	Technical Assistance
1	Appoint HIV/AIDS co-ordinator to report to the CEO	CEO	None	Beginning of Oct. 02	Co-ordinator appointed	N\$800 (advert)	Salary - USAID	None
2	Conduct workshop to incorporate HIV/AIDS into the Healthy City Steering Committee and identify (other) HIV/AIDS agency to be on the Committee	The Mayor	Public and Private Sectors	End of Oct. 02	Workshop	N\$2,000	-	EHO
3	Convene a special meeting of the Healthy City Committee to define HIV/AIDS roles of all members	HIV/AIDS Co-ordinator	None	Beginning of Nov. 02	Roles defined	Nil	Nil	Deputy Mayor
4	To plan, implement, monitor and evaluate	HIV/AIDS Co-ordinator	MOHSS Other line ministries and HIV/AIDS agencies	Every year	Reports	Nil	Nil	EHO

ONGWEDIVA: MANAGEMENT STRATEGIES

STRATEGY AREA: Leadership (Councillors, CEO and Heads of Departments)

OBJECTIVE: To demonstrate leadership, support and commitment for ongoing HIV/AIDS response

INDICATOR: Councillors involved in an increasing number of HIV/AIDS activities

No.	Activities	Responsible Person Lead unit	Other Partners	Time frame	Output	Budget	Fund- ing Source	Technical Assistance
1	To conduct a meeting specifying the role of Councillors in HIV/AIDS responses	The Mayor	Department Heads	—	Meeting	Council	—	HIV/AIDS Co-ordinator
2	Councillors to conduct campaign/s both internally and externally	The Mayor	Department Heads	Three times each year	Campaign	Council	—	Nil
3	Facilitate World AIDS Day activities	Deputy Mayor	MOHSS, Office of the CEO	December each year	World AIDS Day hoste3d	—	Outsour ce	—

ONGWEDIVA: WORKPLACE PROGRAMME

STRATEGY AREA: Training programme

OBJECTIVE: To establish a cadre of appropriately trained support staff

INDICATOR: Trained peer educators running peer education sessions

No.	Activities	Responsible Person Lead unit	Other Partners	Time frame	Output	Budget	Fund- ing Source	Technical Assistance
1	Identify external trainer to train the employee peer educators	HIV/AIDS Co-ordinator	MOHSS, HIV/AIDS Co-ordinator	Beginning Feb. 03	Trainer Identified	Nil	Council	Village Health Care
2	Identify peer educators	Head of Departments	Head of Sections	Beginning Feb. 03	Peer educators identified	Nil	Nil	Nil
3	Conduct peer educator training	External Trainer	MOHSS	Beginning April 03	Training conducted	Nil	Council	Nil
4	Identify suitable time and conduct peer education sessions	Peer educators	HIV/AIDS Co-ordinator	One per month	Peer education sessions conducted	—	Council	—
5	Conduct annual update	HIV/AIDS Co-ordinator	Councillors	Annually	Report	—	—	—

ONGWEDIVA: WORKPLACE PROGRAMME

STRATEGY AREA: Programme for infected and affected staff

OBJECTIVE: To create enabling environment and provide appropriate treatment care and support for infected and affected staff

INDICATOR: Programme in place for infected and affected staff

No.	Activities	Responsible Person Lead unit	Other Partners	Time frame	Output	Budget	Fund- ing Source	Technical Assistance
1.	Identify the staff needs support	HIV/AIDS Co-ordinator	—	—	Staff identified	—	—	—
2.	To promote counselling and voluntary testing	HIV/AIDS Co-ordinator	—	—	Promotion activities	—	—	—
3.	Create a forum of available treatment of Anti Retro Viral drugs to infected staff	The mayor	—	—	Meetings and resolutions	—	—	—

ONGWEDIVA: WORKPLACE PROGRAMME

STRATEGY AREA: Prevention Programme

OBJECTIVE: To promote and support safer sexual practices in a well informed workforce

INDICATOR: Behavioural and attitudes changes regarding the distribution of workforce condoms, reduction in sick leave and deaths

No.	Activities	Responsible Person Lead unit	Other Partners	Time frame	Output	Budget	Funding Source	Technical Assistance
1	Conduct awareness campaigns on special days	The Mayor	HIV/AIDS Co-ordinator	Beginning May 03	Campaign	—	Council	—
2	Conduct Knowledge, Attitudes and Practices (KAP) Survey	HIV/AIDS Co-ordinator	MOHSS, HIV/AIDS Support Group	End May 03	Survey	—	Outsource	External Support needed
3	Develop messages based on KAP survey results	HIV/AIDS Co-ordinator	MOHSS, HIV/AIDS Support Group	Beginning of June 03	Messages developed	—	Outsource	MOHSS
4	Evaluate the prevention programme	HIV/AIDS Co-ordinator	MOHSS, HIV/AIDS Support Group	End June 03	Report	—	Council	—

ONGWEDIVA: EXTERNAL PROGRAMME

STRATEGY AREA: Participation in local government

OBJECTIVE: To ensure effective networking around HIV/AIDS to obtain the optimum sharing of experiences

INDICATOR: Involvement of Council in local Government Fora

No.	Activities	Responsible Person Lead unit	Other Partners	Time frame	Output	Budget	Fund- ing Source	Technical Assistance
1	Identify the local government fora concerned with HIV/AIDS	The Mayor	CEO	—	Fora identified	—	Council	NALAO, ALAN
2	Join the appropriate fora	Council	Neighbouring local authorities	—	For a joined	—	Council	NALAO, ALAN
3	Facilitate for a meetings in Ongwediva	The Mayor	Councillors	—	Meeting/s held	—	Outside source	NALAO, ALAN

Annex C: Cost Assumptions

ESTIMATING THE COST OF HIV/AIDS

This simple model is divided into a number of sheets.

The first is this introduction,

The 'Total' sheet presents the total cost of HIV across all job bands/grades

The 'Result' sheets present results for each band

The 'Á&D' sheets contain the data for each band on which the costings are based

The 'Notes' sheets explain the headings in the 'Results' and 'Á&D' sheets

The 'Limitations' sheet outlines the problems with the model

This model is extremely simplified, this was necessary due to the lack of human resource data available.

It is not intended to provide an accurate estimate of cost, but rather to provide an idea of the order of magnitude

It can also be used as a planning tool to identify major costs and implications of different situations

NOTES

Deaths	Total number of employee deaths from AIDS in current year
Sick leave	
Days	Total number of days sick leave taken as a result of HIV infection in current year
Cost	Cost of sick leave: calculated as number of days*average cash salary
Compassionate leave cols	Cost of compassionate leave taken as a result of the death of colleagues
Productivity	The cost of lower productivity resulting from HIV infection
Recruitment	The cost of recruiting replacement staff for those who have died from AIDS that year
Training	The cost of training replacement staff for those who have died from AIDS that year
Sub total	
Pension fund increase	The cost of increased pension fund contributions necessary to cover increased death benefits
Compassionate leave family	Cost of compassionate leave taken as a result of the death of family members
Housing	The amount of bad debt resulting from outstanding housing loans which the life insurance has refused to cover
Sub total	
Total	
Discounted total	The present value of future costs 2002-2010

Notes

Sick leave in service	The average number of days sick leave taken, per year, up to and including the year of death for employees who die in service
Sick leave retirement	The average number of days sick leave taken, per year, up to and including the year of death for employees who die after retiring of service
Productivity loss	The proportion by which productivity is reduced as a result of HIV infection up to and including the year of death
Productivity days	The number of days work which the lost productivity is equivalent to
Productivity days cost (in service)	The cost of the work day equivalent lost for those who die in service
Productivity days cost (retirement)	The cost of the work day equivalent lost for those who die after retiring from service
Cost per day	The average cost of a lost day of work
Number of working days	Total number of working days per year per employee
Training	The average cost of training a replacement employee
Recruitment	The average cost of recruiting a replacement employee
Average outstanding debt (housing)	The average amount outstanding on an employees housing loan at the time of an AIDS related death
Proportion of life insurance refused	The proportion of life insurance pay outs, resulting from an AIDS death, which are refused on the grounds of an AIDS exclusions
In service deaths	The proportion of AIDS deaths which occur while the employee is still in service
Retirement deaths	The proportion of AIDS deaths which occur after the employee has retired from service
Premature years	The average number of years employees who die of AIDS would have remained at work
Compassionate leave family	The average (across the entire work force not just those who have lost a family member) number of days taken as compassionate leave for a family members death resulting from AIDS
Compassionate leave cols	The average (across the entire work force) number of days taken as compassionate leave for a Colleagues death resulting from AIDS
Staff growth rate	The rate at which the work force is expected to grow each year
Pension fund increase	The percentage increase in pension fund contributions, as a percentage of the salary bill, necessary to cover the cost of increased AIDS deaths
Total staff	Total staffing complement in 2002
Discount rate	The government discount rate

Limitations

The model is limited in a number of ways

Firstly, many of the complicated calculations are exogenous inputs to the model: deaths from AIDS, pension fund increases etc

Secondly, costs are not distributed throughout the year, the discounted amount assumes that they all happen at once

This is not a major concern as it makes little difference to the final result

Thirdly, the model takes little consideration of the difference in costs associated with different levels of employment and differences in age

The work force should be disaggregated by age, and job band and the model run for each.

This was not possible given the limitations of the data.

Finally, the model is limited, as is any model, in that it is only as good as the data which is entered into it.

ASSUMPTIONS AND DATA FOR ALL BANDS

	1	2	3	4	5	6	7	Death				
Sick leave in service	4	0	0	0	0	0	51.827779	103.65556				
Sick leave retirement	4	0	0	0	0	0	103.65556	0				
Productivity loss	0	0	0	0	0	0	0.1	0.1				
Productivity days	0	0	0	0	0	0	16.817222	11.634444				
Productivity days cost (in service)	0	0	0	0	0	0	2875.745	1989.49				
Productivity days cost (retirement)	0	0	0	0	0	0	2875.745	0				
Cost per day	171											
Number of working days	220	Discounted	Net									
Training	1600	603.0231726	996.97683									
Recruitment	500	188.4447414	311.55526									
Average outstanding debt	0											
Proportion not covered	0.1											
In service deaths	0.5											
Retirement deaths	0.5											
Premature years	20											
Compassionate leave family	2											
Compassionate leave cols	2											
Staff growth rate	0											
Benefit increase	0.003											
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	
Total staff	58	58	58	58	58	58	58	58	58	58	58	
Excess mortality	0.0181112	0.020089958	0.0217454	0.022727	0.0232332	0.023502103	0.0233921	0.0230462	0.0229037	0.0226195	0.0227086	
No. close family	5											
Discount rate	0.05											

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