

Volume 3: Oshakati

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	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.

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 town of Oshakati.

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 is based on these surveys. The last such survey completed by MOHSS was in 2000, when the antenatal prevalence rate for Oshakati was 28%. Oshakati now has the third highest prevalence of all the sites surveyed in Namibia, after Katima Mulilo (in Caprivi region) and Windhoek. This results from extremely high levels of in-migration into the town (including that from neighbouring countries) as well as the mobility of the population in the Oshana region, of which Oshakati is the capital.

The implication of this HIV prevalence rate is that close to one-third of the adult population in Oshakati (those aged 15 to 49+ years of age) are now likely to be infected.¹ And, should the epidemic continue to follow past trends, prevalence should peak in Oshakati at 30% by 2004/5 and is projected to remain at that level for the foreseeable future.

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, however, 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 Council officials prior to their incorporation in the model.

The projections indicate that over 5,000 people are presently HIV-positive in Oshakati or some 12% of the town's current population of 42,649. This number is projected to rise to 9,500 individuals by 2012 and just under 12,000 in 2021.

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 data further suggest that over 1,500 people in Oshakati have already died as a result of AIDS and that by 2010 this figure is likely to be close to 6,900 AIDS deaths. The 5,000 deaths estimated to occur 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 18,000, *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 Oshakati will continue to grow, but at a slower rate, growing mainly because of continued high inward migration from other areas. The population of the town is presently estimated to be some 45,000 individuals (2002), but this number would have been far higher in the absence of AIDS. By 2012, the projections indicate that Oshakati's population will now be 27% smaller than it would have been 'without' AIDS, and by 2021 the epidemic will have reduced the size of the town's population by some 29% from what it otherwise would have been.

The socio-economic impacts of HIV/AIDS on Oshakati are therefore likely to be severe. This is because of the number of deaths and 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 most obvious economic impact for the town will occur as a result of the increasing cost of labour. Employers will be faced with rapidly rising illness and death rates among their employees. This will reduce productivity and increase costs, making business and industrial operations less profitable.

The effects of illness and death resulting from AIDS are felt both by individuals and the households in which they live. Infected individuals experience lowered income as they become unable to work. Access to money becomes more difficult, and medical and other expenses increase. The situation is similar at the household level, as individual illness often results in a reduction in household income or production. The impact is then further exacerbated as productive activities and labour resources across the household are diverted towards the care of ill household members resulting in changes in the level and composition of the goods and services they demand. 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 in the town. This will be particularly serious in Oshakati as local businesses offer their services to consumers drawn from throughout northern Namibia. These links with the regional economy mean that the impact of HIV on the region will have economic implications for the town.

The importance of remittances in northern Namibia will create further vulnerability to the economic impacts of HIV/AIDS in Oshakati. The illness of migrants from northern Namibia working elsewhere in the country will affect not only themselves but also the households to whom they send remittances. In Oshakati this means that the household impacts in the surrounding areas, indeed in the entire Northern Region will have a detrimental affect on the retail and service industries in the town.

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 oprhans. It is estimated that there are already 1,700 children in Oshakati 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 5,700 in the

next 10 years. It is important to note that these figures are likely to be an *under-estimate* of the scope of the orphan situation in Oshakati. A study of orphans (SIAPAC, 2002) indicated that many children who are orphaned in the southern and central regions of Namibia are sent to their extended families in the north on the death of their parent(s).

Impacts on Oshakati 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 impact 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 Oshakati Town Council results from HIV-infections acquired some six to eight years ago. The full impact of AIDS on the Council 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 Council 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.

Oshakati Town Council employs some 60 individuals and is projected to lose some 26 of these across all staff grades to AIDS over the eleven-year period. This is based on the assumption that lost staff are replaced but that the total number of those employed remains the same. AIDS deaths among Council staff are projected to rise from between 1 and 2 deaths each year from 2002 until 2005 and they are then are projected to increase to an estimated 3 individuals, peaking at this number in 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 an associated cost 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

Oshakati maintains human resource records and data, and was able to provide the consulting team with much of the personnel data needed to complete this Impact Assessment. However, at the outset 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 collated 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. Oshakati 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 sharply from 15 individuals being absent for 79 days in 1999, to 23 staff who took 175 days of sick leave in 2000 and 107 days in 2001. The drop in sick leave between 2000 and 2001 is associated with reductions in staff numbers resulting from the handover of responsibility for the provision of electricity within the town from the Council to Oshakati Premier Electrical. The epidemic will increase the amount of sick leave taken by Council workers. Analysis indicates that the number of days off taken by Council workers *as a result of AIDS* will increase over 400 days of sick leave per year by 2012.

Council also permits its staff to take up to five days annual compassionate leave in the case of severe illness or death in their families. No data were provided on compassionate leave, but it can be expected to increase as a result of HIV/AIDS and therefore needs to be recorded and monitored by Council.

Benefits

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

Membership of a medical aid plan is voluntary for employees of Oshakati Town Council. Where employees are members, the Council pays 50% of the employee's monthly contribution. The cost of medical aid to the Town Council and to its employees is rising as the number of those requiring AIDS medication increases.

Similarly, employees of Oshakati 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 its 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 the case of Oshakati, managers were most concerned about the impacts of HIV/AIDS on their attempts to build capacity within the Town Council. Oshakati Council is a young institution, having only become fully autonomous in 1995 and thus much effort has gone into institution building and staff training.

In addition, senior managers interviewed indicated that the council does not have many staff with special computer skills. They stated that this implied that if the Town Secretary's office were not operating for a short period of time, then Council business would be delayed. These concerns indicate the need for enhanced succession planning within the Council to mitigate the future impacts of HIV/AIDS.

Costs

Unfortunately Oshakati Town Council declined to make personnel wages and benefits costs available to the consultants, and no increases in these are therefore projected.

However, the economic impact of HIV/AIDS in Oshakati will affect the Council's revenue. The bulk of Oshakati's revenue (87%) comes from rates, electricity, water, and sewage and sanitation. In the period 1998 - 2000, most of these services operated at a profit, the notable exception being water. Council audited accounts for 2001 however indicate that all services, with the exception of the sale of electricity, operated at a loss of N\$2.5 million. HIV/AIDS is likely to exacerbate this situation.

The performance of the economy and the growth rate of the city may affect the level of demand for most of these 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 as this is now outsourced to a private company in which Council has an interest. It is likely that overall electricity sales are related to the performance of the regional economy. Any factor, such as AIDS, depressing the growth of this economy will depress the growth in demand for electricity and therefore the ability of the new electricity company to operate at forecast levels of profitability and thus allow Council to benefit from its shareholding.

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 Municipal 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 Town Council presently sells lands to developers and administers the Build Together Project (BTP). Developers are then required to provide services and build houses for sale to the public. Under the latter project central government, through the Ministry of Regional and Local Government and Housing, provides the Council with funding to operate and manage this revolving housing scheme. These loans 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. Over the period, 2001 and 2021, the population of Oshakati will increase from its present level of

approximately 45,000 to some 65,000 residents. This is smaller than it would have been in the absence of AIDS. It is important that planners include this impact of the HIV/AIDS epidemic now, as any increases in capacity, say for the delivery of serviced land into the informal settlement areas, involve long term planning. This is particularly important in towns such as Oshakati, where investments, such as water pumping stations are a significant cost item.

Equally, the demand for burial space and costs 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 Oshakati are migrants from elsewhere in the north of Namibia. They may well opt to return home while ill and die outside of the town. However, many migrants to the South may simply return to Oshakati town when they are ill because of the proximity of medical and other services.

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.

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 Oshakati. 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 the Municipality of the Town of Oshakati.

- 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 Oshakati is structured as follows:

Chapter 1	Introduction, Structure of the Report, Methodology and Background to the Study
Chapter 2	Oshakati, its community and municipal structure and functions
Chapter 3	The Impact of HIV/AIDS on the town of Oshakati, its population and economy
Chapter 4	The Impact of HIV on the Oshakati Town Council
Chapter 5	The Way Forward

Chapter 2: Oshakati

Introduction

Oshakati, situated in Oshana Region of northern Namibia, is the second largest urban area in the country after the capital, Windhoek (2001 census results). As such it is the economic capital of the north central area of Namibia.

The town was established in 1966 by the *apartheid* regime as the administrative centre of the 'homeland' of the then Owamboland. During this period the town was also the centre of the colonial government's military activities in northern Namibia and, at the time, much of its economy was based around serving these personnel. The town was built in and around existing villages and settlements, making present day town planning and expansion particularly difficult.

Following Independence, Oshakati became the capital of the Oshana Region in 1991 and was proclaimed as a town in 1995 under the Local Authorities Act and is now defined as a Schedule I Part II town. As a result of Oshakati's rapid transition to full town status, the Town Council continues to be aggressively engaged in institutional development and capacity building.

Demographic Profile

In 2001, according to Preliminary Census data, the population of Oshakati was 42,649 individuals, making it the second largest town in Namibia (after Windhoek). These individuals live in 9,147 households with an average size of 4.65 people. Planning estimates used by the Town Council indicate that Oshakati has been growing at a rate of 5.76% per annum since Independence.

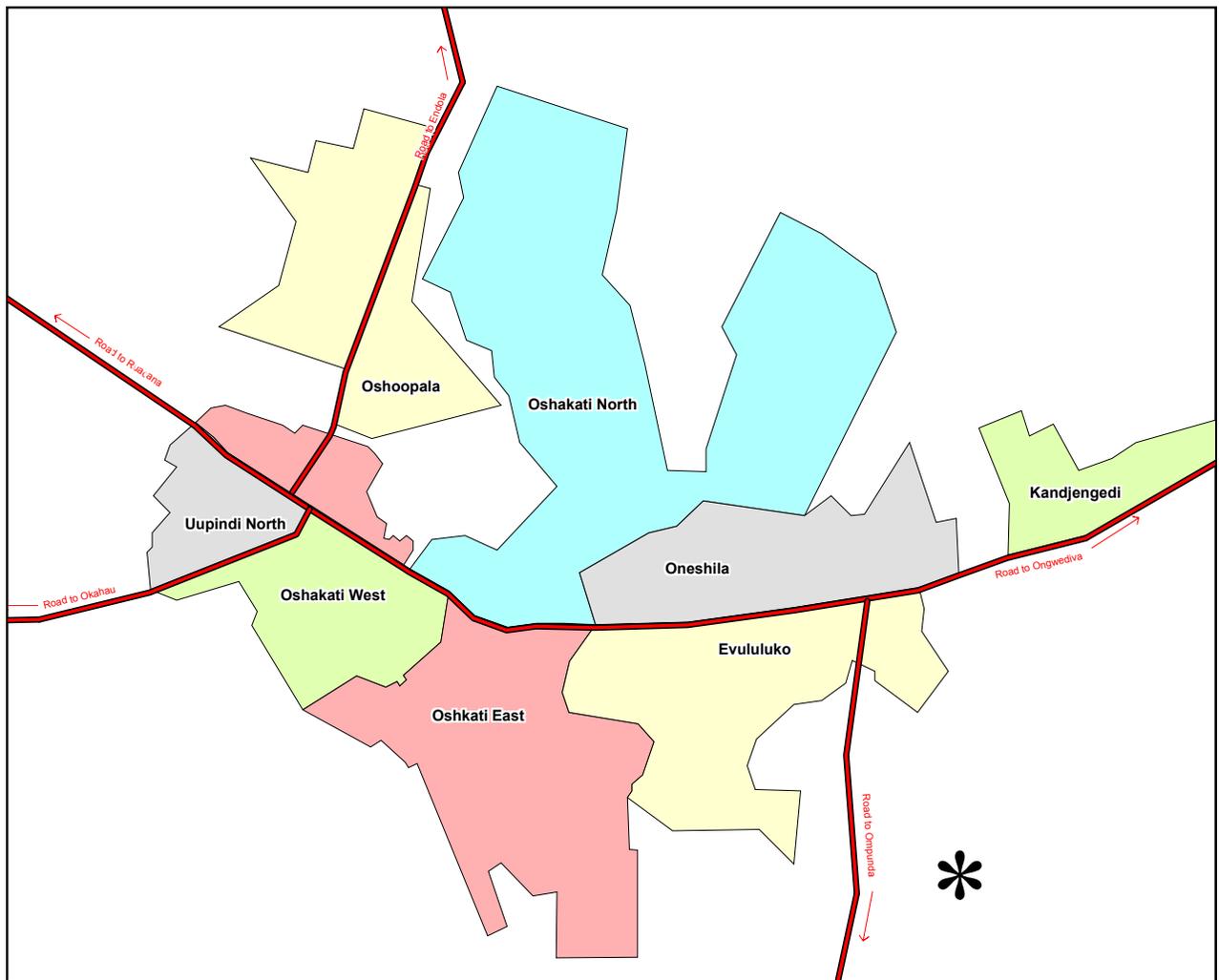
Oshakati has a small formal residential area and much larger informal areas in which close to two-thirds of its residents live. The latter exhibit signs of extremely rapid growth and the town is viewed as an area of first settlement for those from the north central area seeking urban job and economic opportunities, much of this growth is due to in-migration from residents of Oshana and other regions in north central Namibia. Recently arrived migrants tend to gravitate to the informal areas of Oshakati, as evidenced by the rapid growth of new housing, much of which lies in unserviced parts of the informal settlement areas surrounding the town. The following table and map indicate the settlement pattern in the town and the estimated number of residents in each.

Table 2.1: Current Population by Residential Area in Oshakati

Residential Area	Estimated Population (2001 Census)	% per Sector (Structure Plan)*
Formal	9,383	22
Informal	31,134	73
Homesteads	2,132	5
Total	42,649	100

* Derived from the Oshakati Structure Plan (Oshakati Town Council, 2001).

Figure 2.1: Map of Oshakati



Socio Economic Status of Residents

Very limited data on the socio-economic status of the town's residents are available. However, it appears that the majority of its residents are relatively recent migrants (post-Independence). It is likely that younger males predominate, and that this group of residents are both poorer and less well educated than the norm.

No data have been found on household income for the two formal and rateable areas of Oshakati East and West. However, in the informal areas average household income ranges from N\$1,666 to N\$836 per month. Between 25% and 45% of households in these informal areas are self-employed, presumably in informal activities, while for those who are employed, most (approximately 25%) work for government. Equally, over 25% of informal area residents indicate they were unemployed (Oshakati Town Council, 2002).

Economy

North central Namibia has high levels of unemployment (39%) and relies heavily on subsistence agriculture. In Oshana Region itself, crop and livestock production form the basis of the economy and, according to Labour Force Survey data, subsistence agriculture is the main source of income for 45% of the population. The 1998/99 Annual Agricultural Survey indicates that subsistence agriculture consisted primarily of cereal crops, accompanied by livestock production, mainly cattle and goats. 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 ploughing oxen. Migrancy in search of employment and income, from areas surrounding Oshakati, to central and southern regions is common. As a result, many of the households in the region rely on cash remittances, with 8.3% stating that this is their source of primary income, and almost 13% indicating that remittances are their secondary source.

Oshakati, as the region's capital, provides many public and private sector services to the population of Oshana Region and surrounding areas. The town is regarded as the capital of the northern region as a whole, and thus contains important government institutions serving this area's population and these institutions in turn contribute to the local economy.

Equally, the private sector serves this wider community. These businesses range from large retail outlets (most representing major South African chains) to small traders (e.g., the pervasive *cuca* shops found throughout the town) and service operations (such as motor dealers serving the northern region) to financial institutions. These all serve to make the town an important service provider for the entire north central region of Namibia.

In addition, Oshakati is well positioned to take advantage of regional trading opportunities, being proximate to the main roads leading north into Angola. Similarly, the recently concluded peace in Angola as well as current trade negotiations between Namibia and Angola are likely to further stimulate Oshakati's economy.

However, the town's economy does not rely solely on consumptive demand from surrounding regions, but is also the base of limited production. Oshakati is, for example, home to a major brewery that is a significant employer in the town. The Town Council is active in promoting larger scale investment. In addition to the formal sector there are a large and growing number of informal businesses. These are involved in a range of activities including small-scale production.

The town's economy is, therefore, very mixed, involving a range of players, both as consumers and producers of goods and services. The economy of the city is driven by the economic performance of north central Namibia, the development of regional trading opportunities and, in the case of transport, by the success of locally based exporters and importers. The performance and growth of these activities depends on the economy of the entire north central area of Namibia.

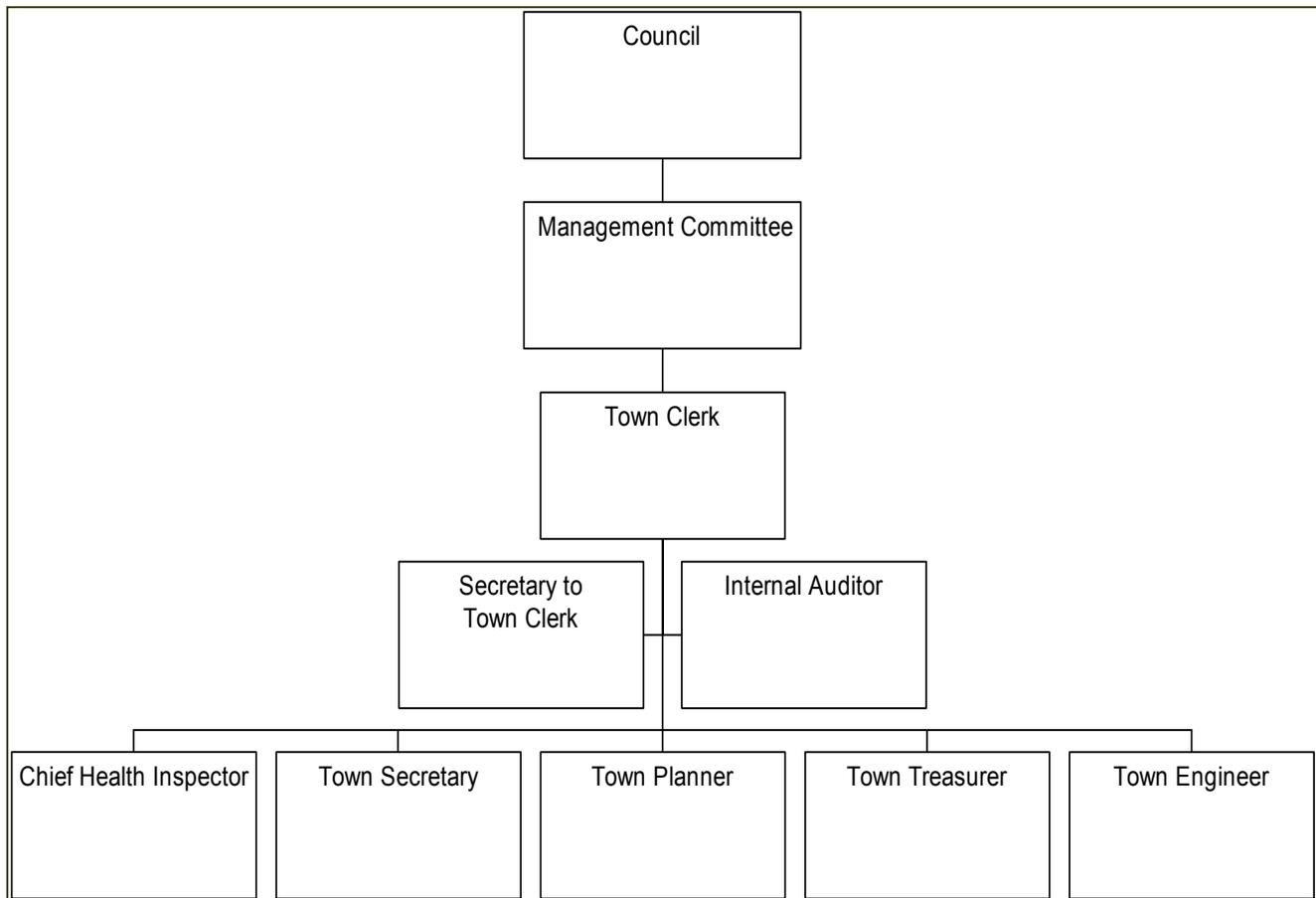
The Town Council

Oshakati Town Council's mission is to provide the best services possible to town residents in order to enhance their standard of living and stimulate revenue flows to develop the town. It

strives to be the economic capital of northern Namibia offering a clean, healthy and attractive environment for all residents in a secure economic and social setting. As a relatively new institution, the Council has focussed much of its attention on capacity building and developing the town in line with its mission statement.

In order to meet these goals, the Town Council employed some 60 staff, working across five departments and reporting through their Town Clerk (as Chief Executive Officer) to a seven member elected Town Council headed by the Mayor. The following figure illustrates Oshakati Town Council's management structure:

Figure 2.2 Oshakati Municipal Structure



It should be noted that until 2001 the Town Engineer's department included responsibility for electricity distribution within the urban boundary of Oshakati. This has now been sold to Oshakati Premier Electrical who operate the service on a shareholding basis with the Town

Council. The company has subsequently absorbed the staff involved the provision of this service, including the electrical engineer.

Key Informants representing senior Council management were interviewed during this Assessment in order to determine the functions of the Town Council and its departments. These findings are presented in the following table:

Table 2.2: Key Functions of the Oshakati Town Council

Department	Key Functions
Town Treasurer	Compile budgets, consolidate all departments' income and expenditure, pay salaries, and other expenses, e.g. vehicle maintenance and insurance, etc. Present monetary reports. Monitor capital budgets. Facilitate income generating projects.
Town Clerk	Personnel and human resources issues. Secretariat to the council. Promoting living conditions of staff. Reports to council. Outline job descriptions. Organise workshops and training.
Health Department	Control of sanitation, and other environmental health issues. Monitor health aspects and identify possible health hazards. Inspection of food commodities. Promote healthy living conditions. Responsible for public health issues, including HIV/AIDS.
Town Engineer	Develop and maintain physical infrastructure such as water, roads, sewerage and refuse removal. The development of new buildings.
Town Planning	Town development in terms of providing information on new developments. Property management, sale of erven. Monitoring development of town.

Core and Peripheral Municipal Functions

In order to inform the analysis of the potential impact of HIV/AIDS on the provision of services to Oshakati residents, Key Informants were requested to identify core (or essential) functions and those that could be defined as peripheral. Those interviewed indicated that all Municipal functions were important, but that the following were considered essential:

- water;
- electricity;
- the development and sale of erven;
- sewerage; and
- roads.

Oshakati is similar to the other municipalities participating in this Impact Assessment in terms of its revenue sources. The bulk (87%) comes from rates, electricity, water, and sewage and sanitation, with most of the remainder coming from the sale of land.

Over the period 1998 - 2000, most of these services operated at a profit, the notable exception being water. However, the Town's audited accounts for 2001 now indicate that all services, with the exception of the sale of electricity, operated at a loss of N\$2.5 million or some 11% of total expenditure (with the loss on the water trading account amounting to some N\$1.75 million). The following table provides data on Oshakati Town Council's operating revenue and expenses over the period 1998 - 2000.

Table 2.3: Revenue and Expenses, Oshakati Town Council (1998 - 2000)

	1998	1999	2000
Total Expenses	17,257,557	18,895,156	23,174,545
Total Revenue	14,494,224	17,958,215	23,293,089

Audited Accounts, Report of the Auditor General.

Services

The services provided, such as water, electricity and sanitation, generate the following profit/loss as follows:

Table 2.4: Revenue and Expenses by Line Item, Oshakati Town Council (2000-2001)

Item	2000		2001	
	Revenue	Expenditure	Revenue	Expenditure
Rates	1,149,387	-	1,707,572	-
Electricity	12,117,692	10,117,692	1,359,307	1,359,307
Sanitation	1,766,760	1,362,790	1,882,823	2,763,031
Water	4,940,437	6,044,218	5,649,005	7,408,678
Surplus/(Deficit)	118,544		(2,559,638)	

Audited Accounts, Report of the Auditor General.

In 2000 the sale of electricity arrangement changed with OTC taking a stake in a new power sales company, Oshakati Premier Electrical. The assets (the local distribution system) were

sold to this newly formed joint venture representing an interest free long-term loan made by the Council to the new company. This accounts for the reduction in income received from this service.

The small formal area of Oshakati town (comprising some 22% of the total population) is fully serviced and planned. This comprises the rateable area of the town. Much of the remainder of the town is unplanned, and residents of these areas are provided with varying levels of services. These range from communal waterpoints and sanitation to no services at all in the town's most recently settled areas.

In the informal areas residents may be granted what is known as Permission to Occupy (PTO) for which an annual fee is paid for the right to settle on a portion of land. These residents may build on this land, and eventually buy it. In addition, Council works with developers who are sold large tracts of land on which houses are built as well as administering the Build Together Programme, for which funds are supplied by central government.

Chapter 3: The Impact of HIV/AIDS on Oshakati

Introduction

This chapter describes the situation regarding HIV/AIDS in Oshakati, its likely impacts on the town's population and its economy, as well as the local response to the epidemic.

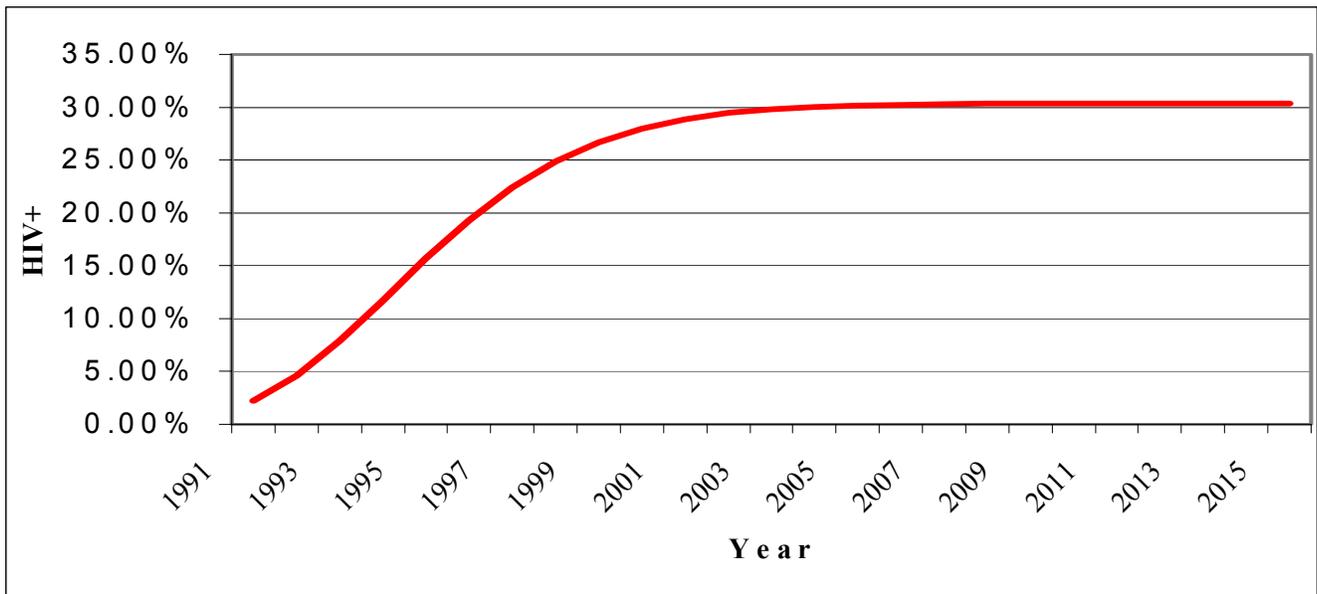
HIV Prevalence

Namibia undertakes antenatal sero-surveillance surveys of the adult HIV prevalence rate every two years. The Ministry of Health and Social Services (MOHSS) undertakes these surveys and all prevalence data in this section of the report are based on these surveys. The last such survey completed by MOHSS was in 2000. In that year, the antenatal prevalence rate for Oshakati was found to be 28%. This high rate of prevalence is some 6% higher than the national average of 22.3%. Together with Walvis Bay, Oshakati has the third highest prevalence of all the sites surveyed in Namibia, after Katima Mulilo (in Caprivi Region) and Windhoek.

This high rate implies that close to one-third of the adult population in Oshakati (those aged 15 to 49+ years of age) are likely to be infected. Unfortunately, Namibia's sero-surveillance data do not provide data on prevalence by socio-economic or educational status, and it thus becomes difficult to assess who is infected and affected by the disease in any location.

HIV prevalence in Oshakati appears to be close to its peak. If the epidemic continues to follow past trends, HIV prevalence should peak in Oshakati at 30% by 2004/5. 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. The following figure projects prevalence in Oshakati over the period 2001 - 2021.

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



This high prevalence rate implies that close to one-third of the population aged 15-49 in Oshakati are likely to be infected. Unfortunately, Namibia's sero-surveillance data does not provide information on prevalence by socio-economic or educational status, and it is therefore difficult to assess who is infected and affected by the disease.

There are a few characteristics of Oshakati that may be driving the epidemic in the town. Firstly, Oshakati appears to be the location of first migration for individuals from the northern regions of Namibia seeking employment and an urban economic base. Secondly, the town appears to experience higher than average economic migration from neighbouring countries (particularly Angola). It should be noted that with the recently concluded peace accord in Angola, the mobility of the populations in the northern regions of Namibia and the southern part of that country is likely to escalate. Finally, there is a great deal of movement of people between the Ongwediva and Oshakati (and the Oshana Region in general) and other areas of Namibia, such as Windhoek, Walvis Bay, etc.

These factors have also resulted in a rapidly growing population, with many people residing in the informal areas of the town where levels of poverty are higher. However, while HIV/AIDS affects everyone, *regardless* of their economic well-being and status in society, the disease is known to 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 Oshakati

This section discusses the demographic impacts of these high rates of infection on the population of Oshakati 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 caution.

The data presented below project the impacts of AIDS on Oshakati's population. 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 Volume 7 (annexes). It is important to note that these assumptions were discussed and agreed to at progress meetings held with 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. Figure 3.2 displays the number of people infected with HIV given the present prevalence rate in the town. As can be seen from the figure, over 5,000 people are presently HIV positive in Oshakati, rising to 9,500 individuals by 2012 and just under 12,000 in 2021.

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

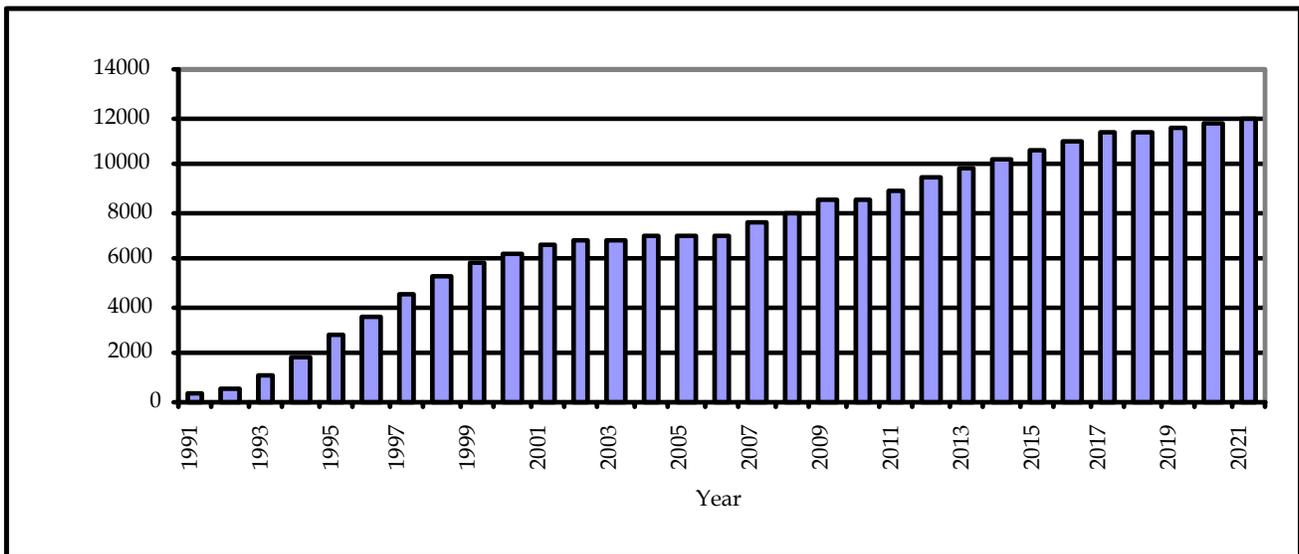


Figure 3.2 illustrates the flow of HIV, with the number of people infected in the early stages of the epidemic increasing rapidly. This is because, at this stage of the epidemic, most of those who are HIV positive are newly infected and the mortality (or death) rate is low. There are,

therefore, many new infections and few exits from the population (the only exit in the case of AIDS being death). Gradually, the rate at which people are infected slows. The reason for this decline in new infections is because a greater proportion of those vulnerable to the disease are already infected with HIV.

In practical terms, this means that at the beginning of the epidemic, when only one person in the town was infected, who 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 HIV infection declines, more of those who are HIV-positive progress to AIDS and die and thus the mortality rate increases. At this stage of the epidemic these two factors combine and the HIV prevalence rate 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.

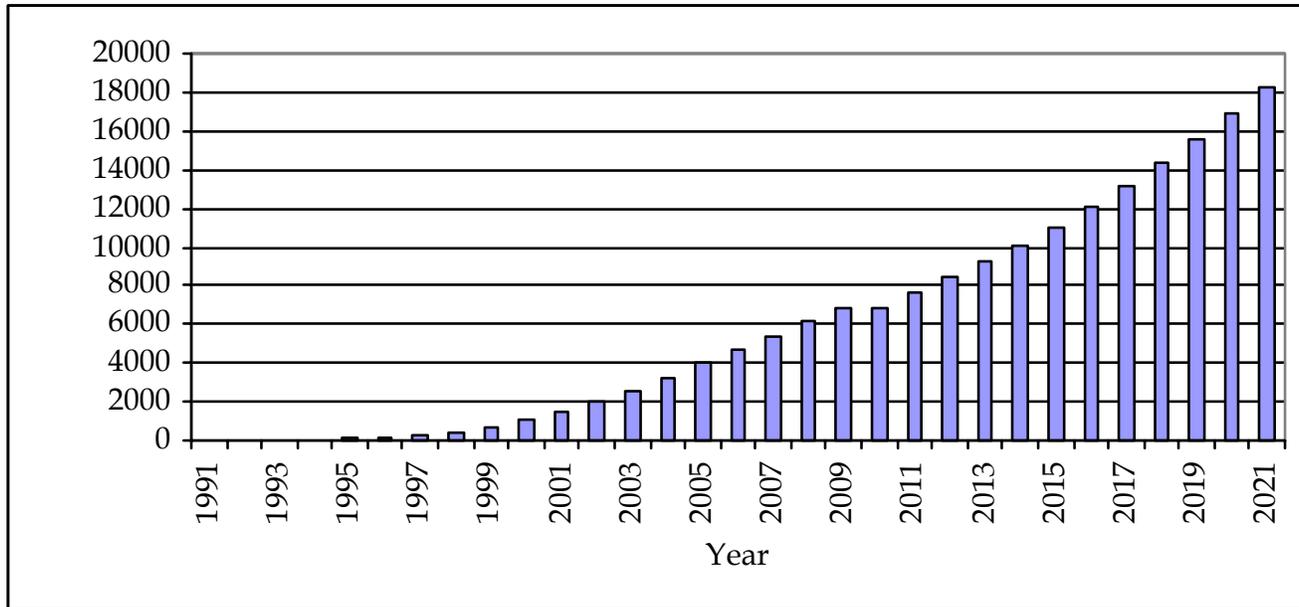
This is illustrated in Figure 3.2 above which shows number of people infected growing rapidly from the beginning of the epidemic until 2001. The growth rate then slowed, when prevalence was projected to stabilise but the number of people infected will continue to increase as the population of the city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

AIDS Deaths

The HIV rate in Oshakati mean that mortality rates in the city will dramatically increase. While HIV prevalence is close to its peak, the lag between infection and death (some 7 to 8 years on average) means that the AIDS epidemic is a number of years behind. AIDS deaths

will therefore only to peak eight years after HIV has peaked. Figure 3.3 indicates number of people who have or are expected cumulatively to die of AIDS.

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



The graph suggests that given the level of infection to date, over 1,500 people in Oshakati have died as a result of AIDS. By 2010 the figure is likely to be closer to 6,900. The estimated 5,000 deaths expected to occur between now and 2010 are largely unavoidable (without access to anti retroviral treatment, which can delay death), 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 18,000, but it is important to stress that *many* of these can be avoided.

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

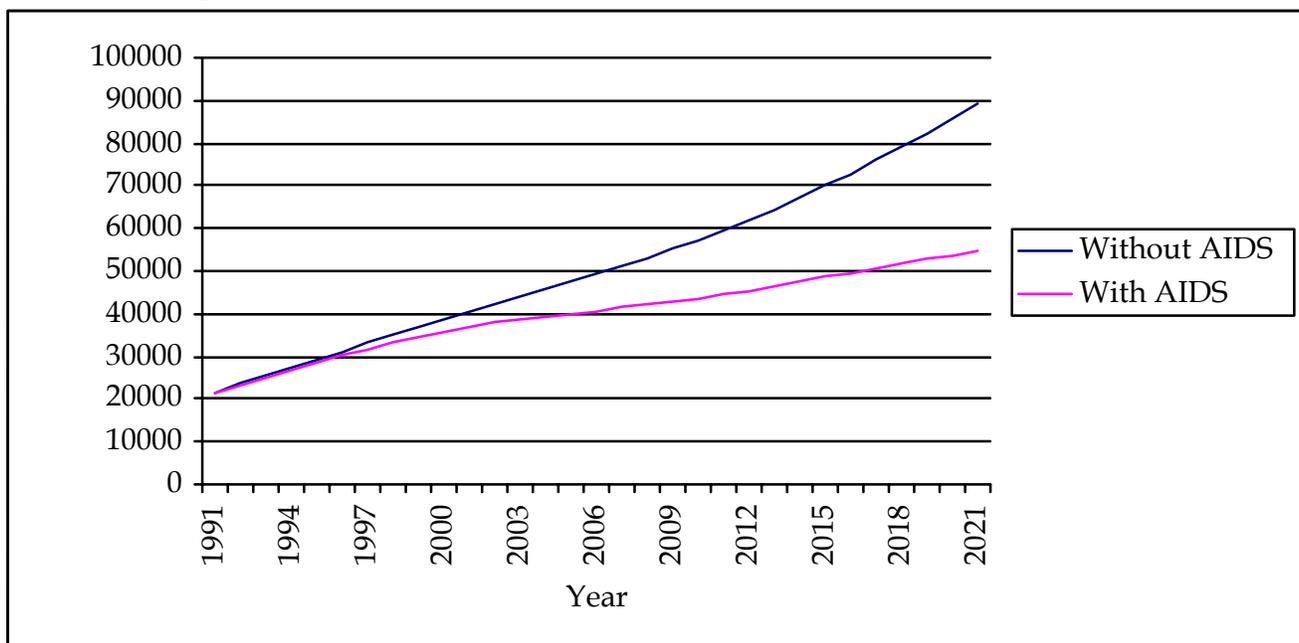
become widely available in the short to medium term due both to its cost and delivery problems as this therapy requires consistent monitoring by health professionals.

Population Growth

These AIDS-related deaths will affect the size of the population of Oshakati 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.

It is, however, expected that the Oshakati 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, Oshakati (1991 - 2021)

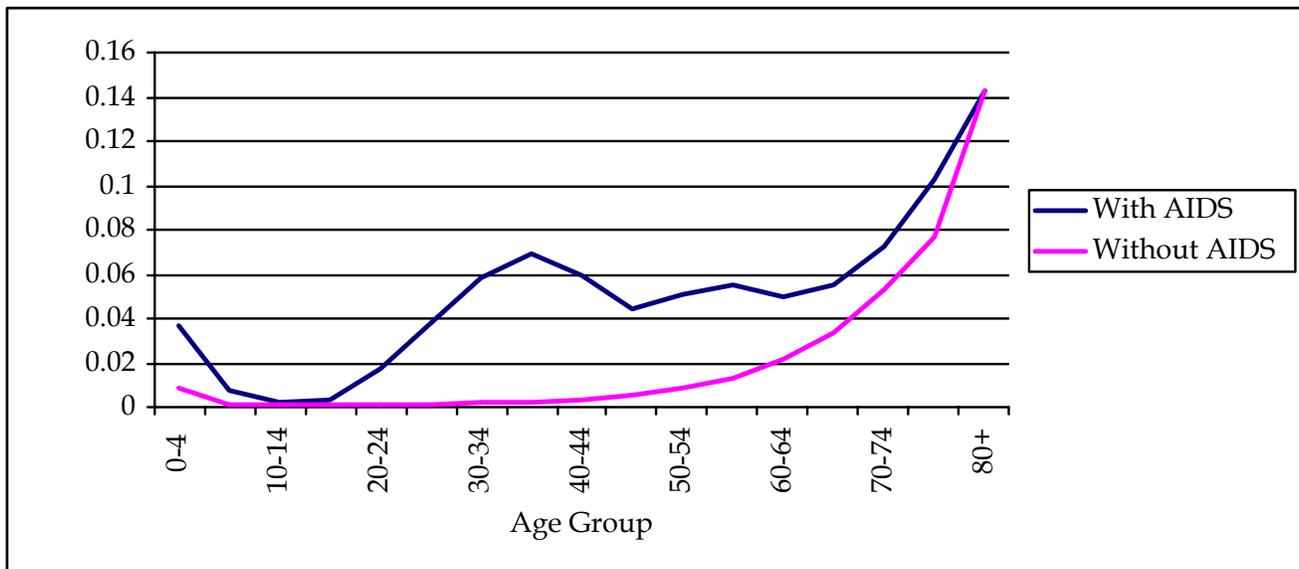


Currently the population of the town is over 45,000 individuals. However, in the absence of AIDS the population would have been closer to 50,000 people by 2002. While the population of Oshakati will continue to grow, Figure 3.4 shows how much larger it would have been by 2021 in the absence of AIDS.

Mortality Rates

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 also its distribution between age cohorts. Figure 3.5 displays the mortality pattern in Oshakati with and without AIDS.

Figure 3.5: Mortality Rates With and Without AIDS, Oshakati



The 'Without AIDS' line demonstrates a typical mortality pattern. Between 0 and 4 years of age, mortality is relatively high as a result of child illnesses. Mortality then remains low for many years, as few people between the ages of 5 and 30 die, and subsequently the death rate 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 10 and 15 will be much the same as very few young children are infected with the disease. AIDS mortality then increases dramatically from the age of 20 peaking at between 40 and 45 years of age. What this means is that 40 year old individuals experience a mortality rate typically associated with that of 70 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 Oshakati and the parents of children living in the city.

Economic Impact of HIV/AIDS on Oshakati

The most obvious economic impact for the town will occur as a result of the increasing cost of labour. Employers will be faced with rapidly rising illness and death rates among their employees. This will reduce productivity and increase costs, making the operations less profitable.

The economic impact will be felt not only by local industries, such as the brewery, but also by households and retail businesses. The affects of illness and death resulting from AIDS are felt both by individuals and by the household in which they live. Individual's who are infected experience reduced productive capacity, often resulting in lowered income, as they become unable to work. At the same time as access to money becomes more difficult, medical and other expenses increases.

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. As HIV is primarily a sexually transmitted disease, households tend to

suffer from multiple infections. The impact on income and production is then further exacerbated as productive activities and labour resources across the household 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. In order to survive these impacts households may be forced to sell assets, borrow money or rely on support from family and friends. While such strategies may dampen impact in the short term, they tend to lead to long term difficulties. Many households in Oshakati are very poor and will consequently have a limited ability to deal with the impacts of HIV. The social consequences of this inability to cope may be far more profound than the economic impacts. For example, some children may be left uncared for, or their access to education reduced, as traditional coping mechanisms are no longer able to cope.

Affected households typically change the level and composition of the goods and services they demand. Expenditure is 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 depending on the goods and services they provide (e.g., those providing health goods and funeral parlours, among others, may experience an increase in the demand for their services), and others, such as furniture retailers, a decrease. As these 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 in the town.

The impact on the entire community will be particularly serious in Oshakati. As discussed in the previous chapter, Oshakati is the central economic city of the entire north central area. Businesses in Oshakati offer their services to consumers drawn from a large area. This is likely to be particularly so for the service industries such as banks. These links with the regional economy mean that the impact of HIV on the area will have economic implications for the town. For example, deaths in the region may affect retail outlets far from Oshakati, but because these retail outlets make use of services provided in Oshakati the deaths will have an economic implication for the town.

As stated previously many households in the region rely on smallholder agriculture, and the loss of labour at key times in such a labour intensive enterprise 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 lose 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. When 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 to be reduced within the entire community.

When income is reduced not only to the household but also to the region there is a ripple effect. Households that lose income are no longer able to send as much money home, affecting the income of shopowners and in turn producers in the region, amplifying impacts on the community. In Oshakati this means that the household impacts in the surrounding areas, indeed in the entire north central area, will have a detrimental effect on the retail and service industries in the town.

The Social Impact of HIV/AIDS on the Community

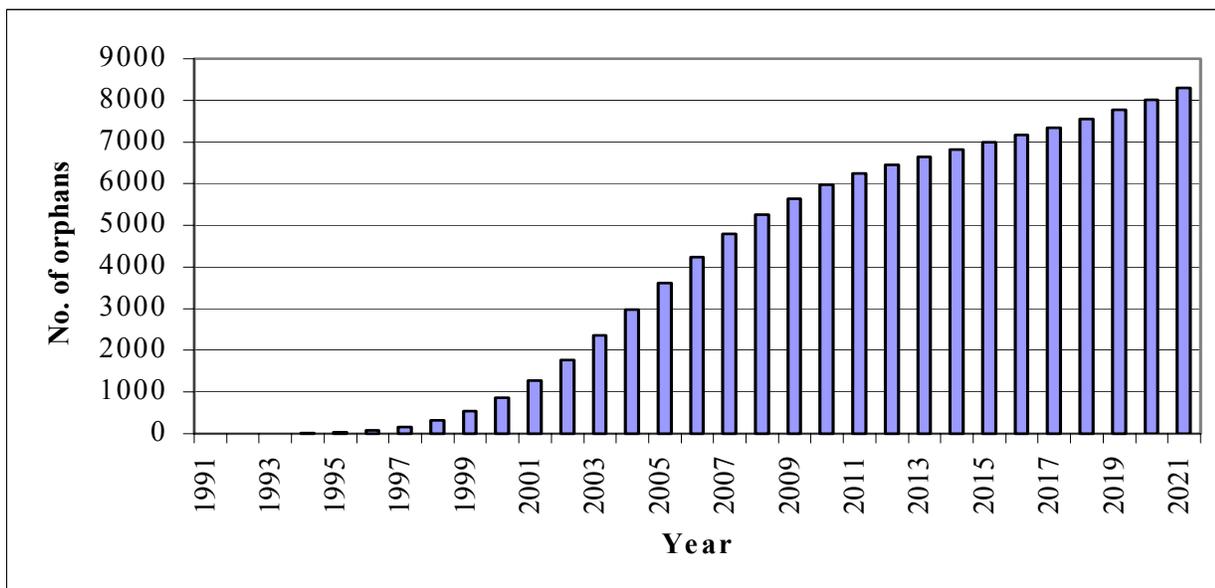
HIV/AIDS profoundly affects families and communities, resulting in the loss of labour and assets, as well as socio-cultural skills, and places almost unprecedented stress on community and extended family networks.

"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 town without parents. The following figure displays the rise in the number of children orphaned as a result of AIDS in Oshakati.

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



It is estimated that there are already 1,700 children in Oshakati who are currently under the age of fifteen and have lost one or both of their parents as a result of AIDS. This number is expected to increase to almost 5,700 in the next 10 years. The ability of community to absorb and care for these children who have lost their parents will be severely strained by this rapid increase in numbers.

“When I was growing up it was impossible to see more than two coffins in church for a burial, but nowadays I find that there are more than four coffins in church for a burial.” SWAG Participant, Oshakati.

The impact of HIV/AIDS on children is arguably the single biggest long-term development impact resulting from infection. 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.

These 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.

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. This will result in reduced ability to provide services at a time when demand is increasing, whether these are offered by the Town Council or not. 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 Oshakati Town Council

Introduction

This chapter reports on the impact of HIV/AIDS on the Town Council of Oshakati. First, the ways in which HIV/AIDS is likely to affect local authorities are discussed. A section detailing the internal impacts on the Oshakati Town Council itself then follows this.

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

Impacts of HIV/AIDS on the Town Council of Oshakati

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 Oshakati 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 an individual's life as HIV progresses towards AIDS that frequent bouts of increasingly more severe illness are experienced. In other words, the AIDS mortality presently being experienced within Oshakati Town Council results from HIV-infections acquired some six to eight years ago. The full impact of AIDS on the Council 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. This is what makes the immediate implementation of planning for the impact of AIDS illness and death within the Town Council so important, in order to prevent future infections, mitigate the impacts of the disease on the functioning of the Council 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* efficiency and revenues, while the personnel losses induced by HIV/AIDS affect the quality of services the Town Council is able to provide. 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.

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, Katabaro and Katahoire, 2000). The reality in Southern Africa appears to be an increasing frequency of bouts of illness, resulting in 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. In addition, the impact on staff morale should not be under-estimated.

"The sad part of HIV/AIDS is that it is killing many educated young people."
FGD Participant, Oshakati.

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 without an expansion

"Generally, most department heads have been exposed to formal training and training workshops. Some have university degrees, while some need to be forced to improve their qualifications. The Council has played its role to expose people to various training methods."
Key Informant, Oshakati.

in the supply of personnel overall, with less funding available for quality and service

improvements. 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.

The epidemic will also impact on the revenue generated by Oshakati Town Council. Households infected or affected by HIV/AIDS will be less likely to be able to pay assessment rates and for services received. The demand for some services (e.g., water) is likely to increase over the short to medium term, and then will only continue to grow at a much decreased rate over the longer-term, but with lowered ability to pay. However, for other services, such as the sale of electricity and land, the demand is likely to decline as both the population growth rates decreases and households become impoverished as a result of the epidemic. As the numbers of these impacted households increase, the town's revenue base is eroded.

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 between 1.5% and 2.6% per annum solely as a result of the disease. By 2020, GDP would thus be some 30% to 52%% less 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

"It is not easy to deal with HIV/AIDS when we have other first priorities. Council priorities make it difficult to deal with HIV/AIDS" Key Informant, Oshakati.

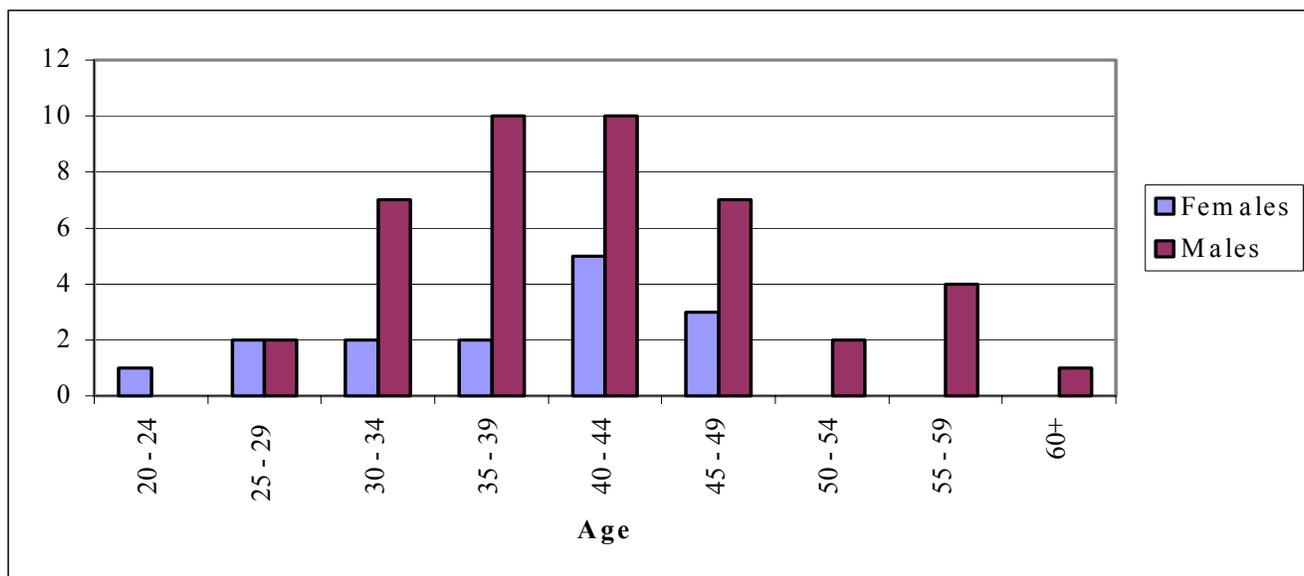
development loans, as AIDS-related demands from all sectors on available resources increase while revenues themselves decrease.

These impacts are particularly pertinent in the case of Oshakati, as the Council is young, and in the process of building itself as an institution, while simultaneously attempting to redress the imbalances of the past. AIDS will make this process more complex and more difficult, and the impacts of the epidemic will require careful monitoring and thoughtful mitigation in order to allow the Town Council to continue to build its own capacity. The remainder of this chapter discusses these impacts on Oshakati Town Council.

Demographic Impacts

In 2001, Oshakati Town Council employed some 60 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 36% 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, Oshakati Town Council (2001)

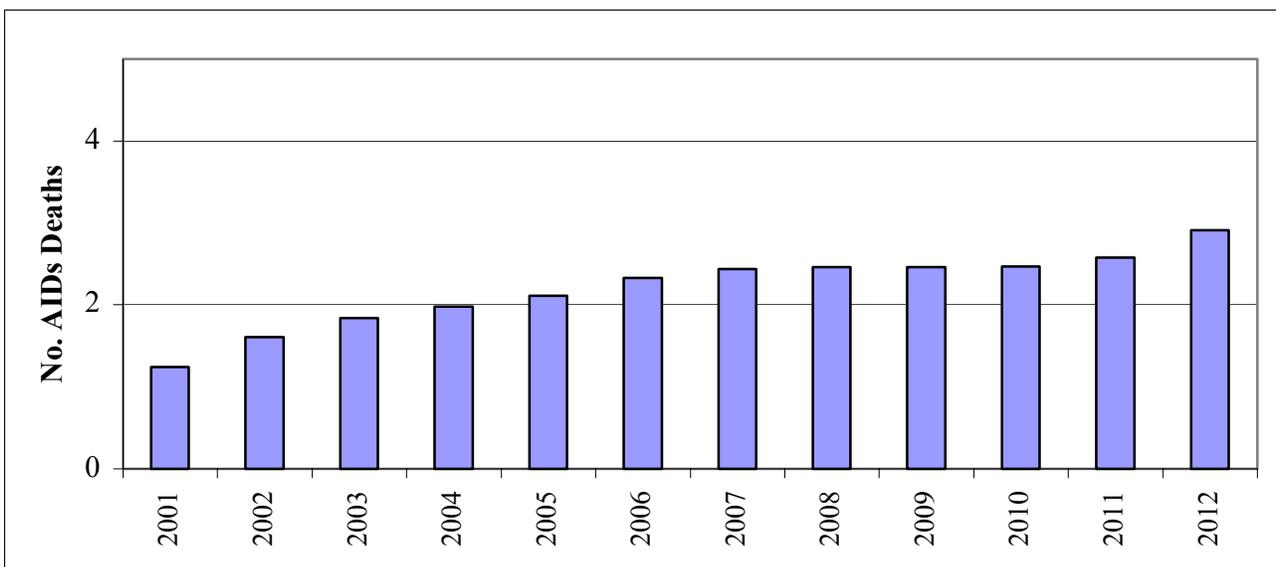


The demographic impacts of the epidemic were projected on this sub-population of Council employees, using the SPECTRUM data developed for the overall population of Oshakati as discussed (and agreed) with Council officials and the Working Group. The basis of the assumptions on which the model is based is discussed in detail in Volume 7 . It is however, important to note that the projections are based on official data from the National Census and the Ministry of Health and Social Services. The period 2001 - 2012 was chosen for the Town Council projections, because, as was explained in the previous chapter, 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 further infections and thus reduce the death rate among its staff beyond 2012.

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

Over period, 2001- 2012 Oshakati is projected to lose some 26 employees across all staff grades to AIDS, provided total staff numbers remain the same. This is illustrated in the following figure:

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



As can be seen from Figure 4.2, above, AIDS deaths among Council staff are projected to continue to rise from between 1 and 2 deaths each year from 2002 until 2005. At this point AIDS deaths are projected to increase to an estimated 3 individuals, peaking at this number in 2012.

The Town Council uses a grading system for staff, from 1 (with grade 3 currently being the highest grade on which staff are employed) to 16. The latter is the lowest of the grades, in which most staff are found (currently 16 individuals, or 26% of the Council's workforce). The AIDS death rate will be highest among these bands, simply because they contain more people.

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 a cost attached to it. These impacts will require management and mitigation, with particular attention being paid to the financial and human resource implications, as discussed below.

Human Resources Management Information System

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

Oshakati maintains human resource records and data, and was able to provide the consulting team with much of the personnel data requested to complete this Assessment. However, some 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 collated monthly, by type and length of leave taken by grade of staff requesting these absences (i.e., whether sick, vacation, compassionate, or bonus leave, etc.). The costs of this leave (by type and grade) will also need to be calculated monthly. These data will allow managers to audit leave trends and track where problems may be developing in terms of absence due to illness or the death of relatives, etc.

Sick Leave

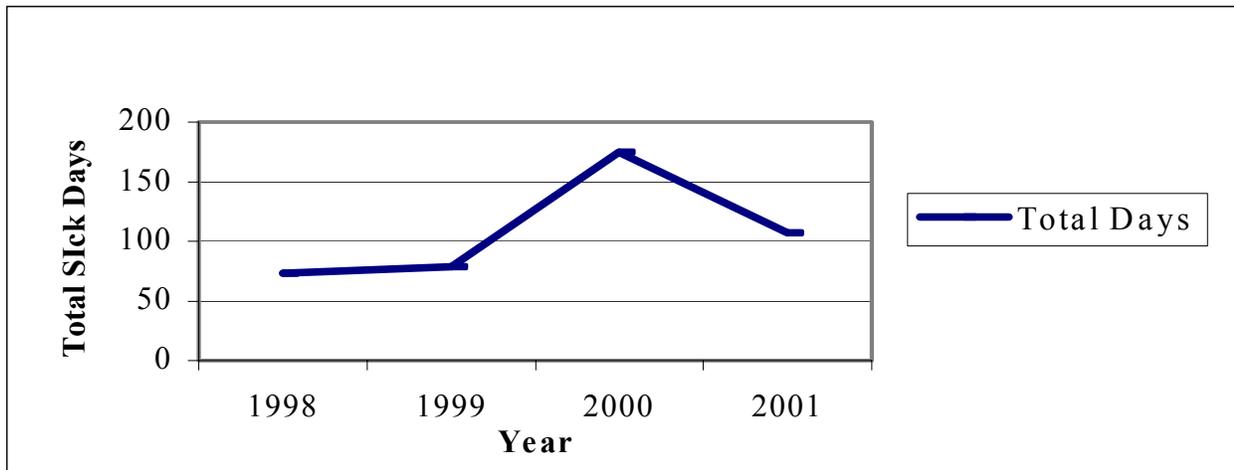
The amount of sick leave taken by staff because of AIDS-related illnesses is one of the main costs of the epidemic to any employer. The reality of HIV/AIDS is that employees who have AIDS become progressively ill, requiring increasingly frequent bouts of sick leave, generally over the last 12 to 18 months of their lives. During this period, the individuals remain on the payroll and cannot be replaced and are substituted by colleagues who act on their behalf, or by temporary appointments.

Sick leave policy is determined by the Local Authorities Act, and Oshakati 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.

“The disease is affecting the quality of people’s work, because they are often absent due to sickness.” SWAG participant, Oshakati.

Over the period 1999 - 2001, the number of staff taking sick leave increased sharply from 15 individuals being absent for 79 days in 1999, to 23 staff who took 175 days of sick leave in 2000 and 107 days in 2001. The drop in sick leave between 2000 and 2001 is assumed to be associated with reductions in staff numbers resulting from the hand over of responsibility for the provision of electricity within the town from the Council to Oshakati Premier Electrical. The following graph illustrates this trend.

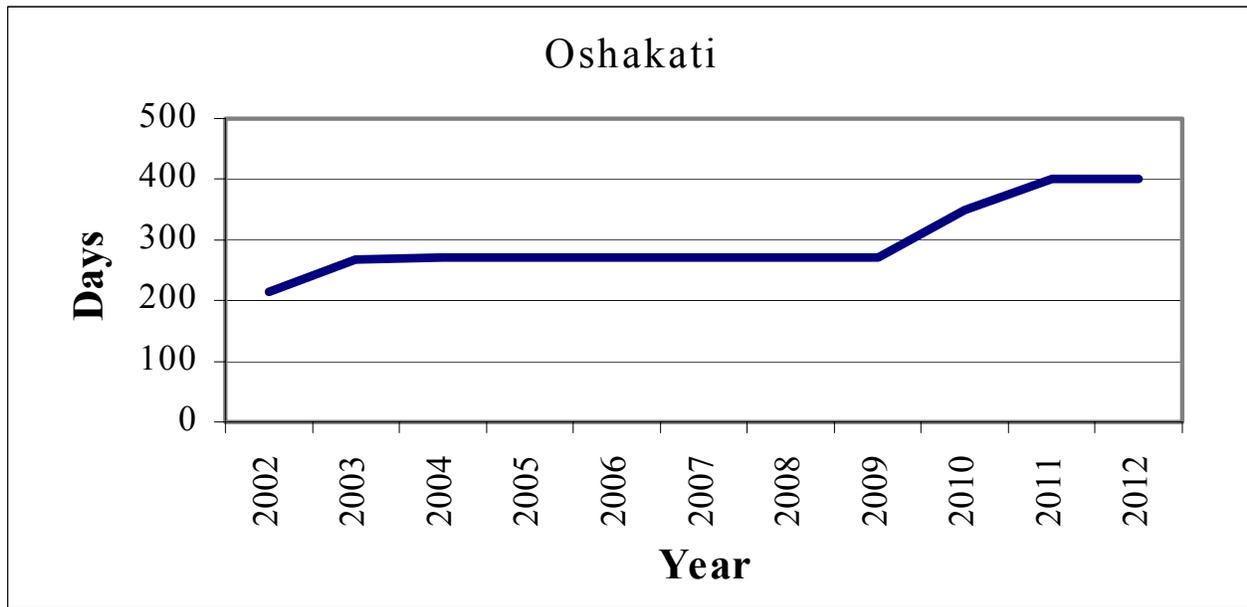
Figure 4.3: Total Sick Leave Days by Year, Oshakati Town Council (1999 - 2001)



Equally, the average number of days per sick leave absence has increased over the three year period, from less than three in 1999 to over seven in 2000.

The epidemic will increase the amount of sick leave taken by Council workers. Analysis indicates that the number of days off taken by Council workers will increase from under 200 in 2001/1 to over 400 days of sick leave per year by 2012. 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 which sick leave has increased. It was then calculated how many days sick leave 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 4.4: Estimated Increase in Sick Leave, Oshakati Town Council (2002 - 2012)



Oshakati has in place a policy catering for employees requiring additional sick leave beyond that contained in its Conditions of Service for Employees. This states that if a staff member has exhausted all accrued sick and other leave, “Council may grant him or her special sick leave for such period and on such conditions as it may approve”. No evidence was found to suggest that the Council has exercised this policy. However, experience elsewhere in the region has demonstrated that, when institutions exercise such open-ended sick leave policies, the costs resulting from AIDS-related absences rise exponentially.

Compassionate Leave

The Council permits employees to take compassionate leave. The allowance is five days per year. However, no data were provided on the amount of compassionate leave being taken by Council personnel, as this is not collected by the Council. It will be important that these absences are recorded and monitored in future.

Medical Aid

Membership of a medical aid plan is voluntary for employees of Oshakati Town Council. Where employees are members, the Council pays 50% of the employee's monthly contribution. This covers the employee, his or her spouse and children. The cost of medical aid to Council and to its employees is rising 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 personnel, as employees are lost to the epidemic early in their careers. 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 Council staff and those trained to degree level. This, in turn, will increase the costs of training provided 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 and Posts

Many of the 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 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 responsible water, refuse removal, housing, etc. Attention will need to be paid to strengthening departments where increased service delivery will be required as a result of the epidemic.

In the case of Oshakati, managers were most concerned about the impacts of HIV/AIDS on their attempts to build capacity within the Town Council.

In addition, senior managers interviewed indicated that the council does not have many staff with special computer skills. They stated that this implied that if the Town Secretary's office were not operating for a short period of time, then Council business would be delayed. If, for example, the cashier was not on duty at the end of the month, then it will result in major problems. If consumers are unable to pay for services, because the cashier was not on duty, and the Town Engineer not informed of this situation, then services will be disconnected because of non-payment for services. If there is a specific problem with water or electricity supply that staff were unable to handle, on a specific day when the Town Engineer is not available, the situation could be damaging.

These examples of critical posts and functions, provided by managers during Key Informant Interviews, clearly indicate the need for succession planning within the Council.

Staff Attrition

The following table presents data on staff attrition over the past three years. It should be noted that the deaths over the past three years mirror the projections discussed above.

Table 4.1: Termination Trends, Oshakati Town Council (1998 - 2001)

Year	Pensioned	Resigned	Dismissed	Deceased
1998	0	1	0	0
1999	8	0	0	2
2000	4	1	1	0
2001	0	0	1	1
Total	12	2	1	3

Pension Fund

Employees of Oshakati 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 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 Retirement Fund for Local Authorities in Namibia Investment Report of 31st 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 4.2: 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.

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 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 the death benefits claim continues to rise.

Cost Data Limitations

Despite repeated requests (during both visits by SIAPAC personnel, in writing, by telephone and electronically), no detailed cost data on salaries and benefits were made available to the consulting team. Information on salaries and benefits were provided but not in terms of actual amounts spent. These costs were requested by grade, indicating the levels of salaries and benefits separately. As no data were made available, no costings will be provided.

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

As noted above, relevant cost data were not provided by the municipality of Oshakati. Therefore, HIV/AIDS impact costs related to internal operations could not be made. The following only refers to external HIV/AIDS impact costs.

Firstly, the economic impact of HIV/AIDS in Oshakati will affect the Council's revenue. The bulk of Oshakati's revenue (87%) comes from rates, electricity, water, and sewage and sanitation. In the period 1998 - 2000, most of these services operated at a profit, the notable exception being water. However, the Town's audited accounts for 2001 now indicate that all services, with the exception of the sale of electricity, operated at a loss of N\$2.5 million (with the loss on the water trading account amounting to some N\$1.75 of this figure).

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 Oshakati, 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 is now outsourced to a private company in which Council has an interest. It is likely that overall electricity sales are related to the performance of the regional economy. Any factor, such as AIDS, depressing the growth of the economy will depress the growth in demand for electricity and therefore the ability of the new electricity company to operate at forecast levels of profitability and thus allow Council to benefit from its shareholding. As an employer the company will also face increasing costs as illness and death increase within its workforce, this will affect its

profitability. The performance of the regional economy will, therefore, influence the revenue of the council through its impact on electricity demand and revenue will be further affected as a result of increased costs of labour. If the electricity company responds by increasing the cost of electricity, this will have a further negative impact on the regions economy as costs of production and service provision increase. Ability to pay for electricity at the household level will also become an issue further depressing profitability from the sales of this service.

As was mentioned with regard to rates, the other major impact on Council revenue will result from the impact of the epidemic on household economies and the ability to pay for services. Studies elsewhere in Africa (for example, in South Africa, Uganda, Tanzania) have found that the greatest such impact on the household occurs just after death. After the long financial strain of recurring illness, the household is then faced with the cost of burial. At these stage households find it difficult to meet other expenses. The impact on municipal revenue resulting from these household impacts will largely be determined by two factors: 1) which expenditures the household sacrifices when these financial problems occur; and 2) if these expenditures include payment for services provided by Council what their response will be.

While it has not been possible to determine the number of households likely to be infected or affected by HIV/AIDS, the epidemic will not be spread evenly across all households. It will cluster, and co-vary with educational levels and poverty.

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 Assessment. However, it may be that those suffering AIDS-related economic shocks would be willing to pay for Municipal services because of the importance of these services, sacrificing other items in their household budget.

If the household has to reduce or redirect expenditure, but they choose to cut back on other products and services rather than those provided by Oshakati Town Council, there will be no impact on revenue. If, however, households stop paying for some or all services provided by

the Council, the impact on revenue will, in turn, be affected by the response of the municipality to this non-payment. If, for example, a household were unable to pay for electricity, the typical response would be disconnection of the service. This response then makes it more difficult for the household to recover from the crisis, as they are now faced with debt and reconnection charges, while during the period of disconnection the municipality is making no profit. Alternatively the municipality could offer a reprieve from payments for a short period of time following a death. This would reduce the pressure on the household. Further, it should result in fewer disconnections, reducing these costs. Once this period has passed the household can 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. This would only be the case for profit-making services such as electricity and rates. While there are other humanitarian reasons to help households that can not pay for water and other non-profitable services, such help would have negative financial implications for the Council and would have to be a policy decision.

In practical terms an alternative policy to disconnections of profitable services could take the form of a two-month reprieve following the death of an account holder. Before such a policy could be adopted further investigations into the financial implications would be necessary.

Land Sales

The sale of land and houses is an important source of revenue for the municipality. Unfortunately, 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 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 would be affected by HIV/AIDS via the epidemic's impact on the local and regional economy. These are likely to result in reduced sales.

The Town Council presently sells lands to developers and administers the Build Together Project (BTP). Developers are then required to provide services and build houses for sale to the public. Under the latter project central government, through the Ministry of Regional and Local Government and Housing, provides the Council with funding to operate and manage this revolving housing scheme. These loans 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.

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, then there will be an increase in administrative costs, possible loss of revenue and a decline in profitability.

Administrative costs will increase as deaths increase from 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 in itself can be expensive. This may be further complicated if a household is left impoverished by the impact of AIDS or contains orphans who have no alternative accommodation.

Even if outstanding debt is covered by an insurance policy, death will decrease the profitability of sales. Sales of property 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.

Revenue Growth

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 town, in terms of area and population. In the demographic section of the previous chapter, the slowing in the rate of population growth was discussed. Over the period, 2001 and 2021, the population of Oshakati will increase from its present level of approximately 45,000 to some 65,000 residents. This is some 24% smaller than it would have been in the absence of AIDS, in which case the population projection indicated that the size of the town would have been over 86,000 people.

This slowing in population growth will translate into a reduction in the rate of revenue growth. However, as growth in expenditures is also slowed, 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 the delivery of serviced land into the informal settlement areas, involve long term planning. This is particularly important in towns, such as Oshakati, where investments such as water pumping stations are a significant cost item.

Equally, the demand for burial space and the costs 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 Oshakati are migrants from elsewhere in the north of Namibia. They may well opt to return home while ill and die outside of the town. However, many migrants to the South may simply return to Oshakati town when they are ill because of the proximity of medical and other services.

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 is therefore experiencing the associated increasing costs of labour. The magnitude and implications of these increasing costs was discussed earlier in this chapter. Clearly, they will increase the expenditure of the municipality while no increase in revenue or provision of services 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 problem is likely to be changing housing demand. Within ten years there will be over 6,000 orphaned children in Oshakati (perhaps more if orphans are sent to Oshakati from the south and west of Namibia). Planning for their housing needs will require the introduction of differing planning designs and standards. 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 services. These new services will require not only additional staff, but also new programmes and materials. The introduction of these and other new services obviously have cost implications.

The Municipal Response

In completing this Assessment, concern as to the impact of HIV/AIDS on programmes and service provision was expressed by Council officers. The Council has recently developed a Workplace Policy and Programme, but the qualitative interviews conducted with municipal employees indicate that as yet there is little or no awareness of this. Council has appointed a committee which is responsible for their implementation.

Participants in the qualitative interviews conducted in Oshakati indicated that "nothing is going on in our local authority with regard to HIV/AIDS". They do not have clubs or groups or attend any HIV/AIDS related meetings. One participant did remember that the Red Cross visited them in 2000 to talk about HIV/AIDS, but only a few employees attended. Most others indicated that they had only heard about HIV/AIDS over the radio.

"I am scared to know my HIV status. I am scared about living with the disease. I don't want to think about all these things."
FGD Participant, Oshakati.

Knowledge, Attitudes and Practice

Nearly all the Council personnel interviewed had correct information as to HIV and AIDS and how the virus is transmitted. A few, however, had misconceptions or were confused about the information they had received.

"I know there is HIV and AIDS. But I do not know is which part is the virus and which part the disease."
FGD Participant, Oshakati.

Over half of those interviewed indicated they knew of some one who had died of AIDS, generally a relative or colleague and all of those interviewed believed that they had colleagues within the Council who could be HIV-positive.

In responding to a series of attitudinal statements about HIV and AIDS, participants all indicated that people with AIDS should not be isolated, and that those infected with the virus required care and support. Participant responses to attitudinal questions and the reasons for their answers are presented below.

Table 4.3: Attitudes among Council Employees

Statement	Agree	Disagree
Questions "I don't think that there is anyone in our local authority that has the AIDS virus."		All
Reasons for "disagree": <ul style="list-style-type: none"> • It would be impossible because 7 out of 10 people are 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 as a result attracts young girls who do not have much • Sometimes top rank people have sex with young girls in exchange for jobs • Sometimes young girls from poor families seek these men 		
Question "If someone is known to have the AIDS virus, they should be isolated."		All
Reasons for "disagree": <ul style="list-style-type: none"> • The majority of the people in Namibia are infected. Only a few people are going to left if HIV positive people are isolated • People in isolation will die quicker • Emotional depression would kill people in isolation and not HIV/AIDS • Sick people needs love and care 		
Questions "Households that are taking care of an AIDS patient are avoided by other households."		All
Reasons for "disagree": <ul style="list-style-type: none"> • People are giving their support • One never knows when the disease will affect one's own household, so one should give love and care to those households 		
Question: "A number of people believe that they can be cleansed of the AIDS virus if they have sex with a virgin."	All	
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."	1	7
Reasons for "disagree": <ul style="list-style-type: none"> • One male participants said it is important for women to explain why they refuse to have sex without a condom so that men understand Reasons for "disagree": <ul style="list-style-type: none"> • One female participant agreed because if not then the man will beat the wife 		
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."	5	4
Reasons for "agree": <ul style="list-style-type: none"> • It will depend on the two partners 		
Question: "If a shopkeeper has the AIDS virus, I would still buy products from them, including fresh produce."	ALL	
Reasons for "agree": <ul style="list-style-type: none"> • They know that HIV/AIDS cannot be transmitted through casual contact 		

Intervention Activities

Participants in the qualitative interviews were asked to discuss those interventions they believed would be effective within Oshakati. These are discussed below, while the detailed findings across the interviews can be found in Volume 7.

Participants felt that the Council should do more to prevent infections among both its staff and the community they service. Most participants believed that specific staff should be designated to coordinate AIDS awareness and support for those already HIV-positive. Those interviewed made the following suggestions as to activities they believed would increase awareness among Council staff, leading to reduced infections and greater support of those who were HIV-positive.

" Enough talk has been done about HIV/AIDS, we need to take action."
SWAG participant, Oshakati.

Condoms

All participants agreed that condoms should be distributed free of charge to all Council employees and customers in order to encourage their use. These should be placed in places where people have free access to them as some people would not take condoms if others who see them doing this.

Awareness Raising

The municipality should organise workshops where HIV/AIDS related issues are discussed. Several participants believed these should be for smaller groups and held frequently. As employees of Council, and those working in the town live in different places (such as Ongwediva and Ondangwa) participants stressed that workshops should not only be in Oshakati but also held in these areas. This would ensure that employees and their families could become part of the awareness raising process, as well as community members. Awareness raising events should take place in the afternoon during working hours, because during the late afternoon (working hours) people are not too busy. Awareness raising events need to be seen to be supported by different stakeholders in town.

Financial Support

The Town Council budget should allocate a certain amount of money for HIV/AIDS-related issues. Officials within the municipality should be tasked to lobby for financial assistance to deal with the disease, and these funds should be used for the benefit of infected employees and their families. All participants agreed that financial support to infected people is necessary. One participant indicated that they could lobby for funds from sister cities, such as Windhoek, or request for funds from donors and organisations such as WHO and UNICEF.

Interventions to Reduce High Risk Behaviours

Most participants believed that the municipality should link HIV/AIDS to its vision and mission statements. 'This would allow the organisation as a whole to have the same aspirations, because employees always think like other people within the organisation. People usually identify themselves with their organisations'. One participant felt that this is where religion could play a vital role. Churches should encourage people to stick to one partner and that they should be faithful to one partner as a change in behaviour is desperately needed.

Political Will

Politicians and government leaders are viewed by employees of Oshakati Town Council as highly influential people who have the ability to get people to change their behaviours. 'These leaders should talk about HIV/AIDS more often and more freely. These presentations should not only be on TV or radio because not all people have these. Participants noted that Mayors are already involved in talking to people about HIV/AIDS but stated they should do it more often'. It was noted that Town Councillors usually organise meetings to talk about development. 'These types of meetings should also be used to talk about HIV/AIDS as well. Town Council Councillors should be serious in addressing issues of HIV/AIDS and state clearly that the disease is a dangerous threat to the Namibian nation'.

Testing, Counselling and Treatment for HIV Positive People

'Testing, counselling and treatment interventions would only be acceptable if HIV/AIDS results are kept a secret. If confidentiality were not taken seriously then people would be reluctant to go for testing, counselling and treatment'. 'Peer educators should be trained, and they should take the issue of confidentiality very seriously'.

Destigmatisation

Participants felt strongly that, the more AIDS is spoken about, the more stigma would decrease. Thus, 'HIV/AIDS talks should be part of every meeting in the workplace, whether formal or informal. Strong communication in the workforce would make such interventions acceptable and effective. Facilitators who deal with HIV/AIDS issues should use simple language for all to understand'. Some participants still associated the epidemic as a gay disease, and felt that current stigma was in part associated with this.

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 the three areas discussed below.

Management Strategies

These are to assist the local authority identify, plan for 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 around 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 the Oshakati Town Council. The intention of these strategies is to widen the Council's response to the epidemic through enhanced linkage with and support to existing government and non governmental organisation programmes and activities.

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

GOAL: To lessen the HIV infection rate in Oshakati and to enhance comprehensive prevention measures.

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.
- 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 particularly pertinent in regard to the human resource management systems presently in place within each local authority. While most are able to 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. These need to 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 Oshakati are contained in 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 Oshakati is to be presented to Council for approval and action. However, the draft plans included in the final report will require further elaboration and, perhaps, amendment, by Council 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. 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, AMICAAL can assist in developing and implementing the plans to mitigate the impacts of HIV/AIDS on each municipality. However, 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 HV/AIDS to these national associations as well as other bodies.

Annex A: Active HIV/AIDS Organisation

The following AIDS Support Organisations (ASOs) are listed as operating in the Oshakati 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 (NNNP+/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 of 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**

OSHAKATI: MANAGEMENT STRATEGY

STRATEGY AREA: Baseline and Periodical Assessment

OBJECTIVE: To generate a clear 'picture' of the epidemic currently and in the future

INDICATOR: Final Impact Assessment report and steps identified

No.	Activities	Responsible Person Lead unit	Other Partners	Time frame	Output	Budget	Fund- ing Source	Technical Assistance
1	Develop terms of reference and allocate a budget for Impact Assessment Review	HIV/AIDS Committee	Treasurer, Shop Steward and CEO	Aug. 03	ToR in the Budget	TOC	GTZ	SIAPAC
2	Tender the ToR, and select and appoint suitable tender	Tender Board	AIDS Committee	Oct. 03	Consultant Appointed	_____	_____	_____
3	Monitor the Implementation of the ToR	HIV/AIDS Committee	_____	Nov. 03 Feb. 04	Draft Report	_____	GTZ	_____
4	Compile and present the findings of the consultant's reports and identify the next steps	HIV/AIDS Committee	Consultant	March, 04	Final Report and Next Steps	OTC	GTZ	

OSHAKATI: MANAGEMENT STRATEGY

STRATEGY AREA: Structure and Planning

OBJECTIVE: Strengthen and Support the Existing Structure to Plan, Implement and Monitor Town HIV/AIDS response

INDICATOR: Approved Expanded Terms of Reference

No.	Activities	Responsible Person Lead unit	Other Partners	Time frame	Output	Budget	Fund- ing Source	Technical Assistance
	Review ToR to accommodate broader responsibilities	HIV/AIDS Committee	CEO	Sept. 02	Reviewed Proposed ToR	_____	_____	SIAPAC
	Submit ToR to Council for Approval	HIV/AIDS Committee	Council	Sept. 02	Approved ToR	_____	_____	_____

OSHAKATI: MANAGEMENT STRATEGY

STRATEGY AREA: Leadership Commitment

OBJECTIVE: To Demonstrate Leadership Support and Commitments on HIV/AIDS

INDICATOR: Monthly HIV/AIDS Meetings Attended and Supported

No.	Activities	Responsible Person Lead unit	Other Partners	Time frame	Output	Budget	Fund- ing Source	Technical Assistance
1	Conduct report-back meeting to politicians and officers	HIV/AIDS	—	Aug. 02	Report meeting held	—	—	—
2	Encourage meeting participants to report to their subordinates	HIV/AIDS Committee	—	Sept. 02	Departmental level report-back meeting held	—	—	—
3	Monthly progress report to politicians and head of departments	HIV/AIDS Committee	—	Sept. 02 onwards	Monthly meetings held	—	—	—

OSHAKATI: MANAGEMENT STRATEGY

STRATEGY AREA: Data Allocation and Data Analysis

OBJECTIVE: Collect accurate data, analyse and utilise it to inform the town HIV/AIDS response

INDICATOR: Monthly summary and detailed annual report

No.	Activities	Responsible Person Lead unit	Other Partners	Time frame	Output	Budget	Fund- ing Source	Technical Assistance
1	Develop the ToR and budget to set up a HIV/AIDS data collection on system in the Town Council	HIV/AIDS Committee	Personnel Officer, Treasurer, CEO	Sept/Oct. 02	ToR, Budget	OTC	GTZ	SIAPAC
2	Put to tender and appoint a consultant	Tender Board	HIV/AIDS Committee	Nov. 02 – Jan, 03	Appoint a consultant	—	—	—
3	Monitor the implementation of the ToR and the development of the training material	HIV/AIDS Committee	HR personnel officer	Feb. 03 – April, 03	Training materials prepared	OTC	GTZ	—
4	Commencement of training followed by data collection and review	Consultant	HR, PO and HIV/AIDS Committee	May. 03, onwards	Trained materials and data collected analysed	OTC	GTZ/ OTC	—

OSHAKATI: INTERNAL WORKPLACE PROGRAMME

STRATEGY AREA: Programme for Infected and Affected Staff

OBJECTIVE: Create and enabling environment and provide appropriate treatment, care and support for infected and affected staff

INDICATOR: Increased public disclosure of status

No.	Activities	Responsible Person Lead unit	Other Partners	Time frame	Output	Budget	Fund- ing Source	Technical Assistance
1	Identify partners for campaigns to encourage VCT and positive learning	Committee	NGOs, Medical Aid, MHSS, and other stakeholders	Jan. 03	Partners identification	—	—	—
2	Meet with partners and plan VCT and positive living campaigns	Committee	NGOs, MHSS, Medical Aid	Feb. 03	VCT and Positive Living Campaign	OTC	OTC	—
3	Conduct Campaign	Committee	NGOs, MHSS, Medical Aid	March, 02 onwards	Campaign conducted	OTC	OTC	—
4	Evaluate Campaign	Committee	NGOs, MHSS, Medical Aid	March, 04	Evaluation Report	OTC	OTC	—

OSHAKATI: INTERNAL WORKPLACE POLICY

STRATEGY AREA: Training Programme

OBJECTIVE: To establish a cadre of appropriately trained and supported staff

INDICATOR: Peer educators trained and implementing peer education

No.	Activities	Responsible Person Lead unit	Other Partners	Time frame	Output	Budget	Fund- ing Source	Technical Assistance
1	Identify a master peer education trainer	HIV/AIDS Committee	HR, CEO, Treasurer	Oct. - Nov. 02	Master Peer Educator Trainer Identified and Appointed	---	---	---
2	Identify Trainees for Trainers of Trainers	HIV/AIDS Committee	OTC	Nov. 02	Trainees Identified	---	---	---
3	Conduct Training of Trainers	Master Trainer	HIV/AIDS Committee	Jan. 03 - Feb. 03	Training of Trainers Conducted	OTC	GTZ/OTC	---
4	Identification and Training of Peer Educators	HIV/AIDS Committee and Trainers	OTC	Feb. 03 onwards	Peer Educators and Trainers	OTC	OTC	---

OSHAKATI: INTERNAL WORKPLACE POLICY

STRATEGY AREA: Preventive Programme

OBJECTIVE: To promote and support safe sexual practices in a well informed workplace

INDICATOR: Improved awareness based on KAP survey results

No.	Activities	Responsible Person Lead unit	Other Partners	Time frame	Output	Budget	Fund- ing Source	Technical Assistance
1	Identify partners in the awareness campaign	HIV/AIDS Committee	NGO, MHSS and other stakeholders	Sept. - Oct. 02	Partners in awareness identification	—	—	—
2	Meet with partners and plan an awareness raising programme	HIV/AIDS Committee	NGOs and MHSS	Oct. - Nov. 02	Awareness programme	—	OTC	—
3	Implement awareness programme	HIV/AIDS Committee	NGOs, MHSS, HODs	Oct. 02 ongoing	Awareness programme conducted and condoms distributed	—	OTC	—
4	Conduct a KAP Survey	Council advisor	OTC	Oct. 03	KAP Survey	—	OTC	—

OSHAKATI: INTERNAL WORKPLACE PROGRAMME

STRATEGY AREA: Workplace Policy

OBJECTIVE: Implement a Comprehensive Workplace Programme

INDICATOR: Report indicating adherence to the policy

No.	Activities	Responsible Person Lead unit	Other Partners	Time frame	Output	Budget	Fund- ing Source	Technical Assistance
1	Organise and call meetings to explain and translate the HIV/AIDS policy to all employees	HIV/AIDS Committee	Mayor, CEO, HR	Sept. 02 onwards	Explanation of meeting held	_____	_____	_____
2	Set up programmes outlined in the policy	HIV/AIDS Committee	IBIS Advisor, HR	Sept. 02 - Oct. 02	Programme Set-up	_____	_____	_____
3	Monitoring adherence to the policy	HIV/AIDS Committee	IBIS Advisor	Ongoing	Report on adherence to policy	_____	_____	_____

OSHAKATI: EXTERNAL PROGRAMME

STRATEGY AREA: Participation in Community HIV/AIDS Response

OBJECTIVE: To join, participate and enrich community HIV/AIDS responses and ensure effective net-working

INDICATOR: Community forum held and the identification of the way forward

No.	Activities	Responsible Person Lead unit	Other Partners	Time frame	Output	Budget	Fund- ing Source	Technical Assistance
1	Plan community forum	HIV/AIDS Committee	RACCOC, MHSS, CAG	Feb. 03	Community Forum Planned	OTC	OTC	—
2	Tabling of plan for debate for approval	HIV/AIDS Committee	OTC	March. 03	Plan approved	OTC	OTC	—
3	Convene Community Forum	HIV/AIDS Committee	OTC	April. 03	Community Forum held	OTC	OTC	—

OSHAKATI: EXTERNAL PROGRAMME

STRATEGY AREA: Baseline and Periodical Assessments

OBJECTIVE: To collect, analyse and utilise information to inform and support the Town external HIV/AIDS response

INDICATOR: Up to date data base

No.	Activities	Responsible Person Lead unit	Other Partners	Time frame	Output	Budget	Fund- ing Source	Technical Assistance
1	Acquire existing directories of organisations working in HIV/AIDS area	HIV/AIDS Committee	Council Advisor	Sept. - Oct. 02	Directories acquired	_____	_____	_____
2	Set up a data base of information on the activities	Co-ordinator and HIV/AIDS Committee	Consultant	Oct. - Nov. 02	Data base sat up	_____	FHI	FHI
3	Contact NGOs and capture data on current activities	Co-ordinator and HIV/AIDS Committee	Consultant	Nov. 02 - Nov. 03	Data base on current activities	_____	FHI	FHI
4	Maintain data base	Co-ordinator	_____	Ongoing	Up to date data base	_____	OTC	_____

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.

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